Filing at a Glance

Company:	UnitedHealthcare Insurance Company
Product Name:	2017 Railroad COC Filing
State:	District of Columbia
TOI:	H21 Health - Other
Sub-TOI:	H21.000 Health - Other
Filing Type:	Form
Date Submitted:	11/11/2016
SERFF Tr Num:	UHLC-130805292
SERFF Status:	Assigned
State Tr Num:	
State Status:	
Co Tr Num:	50086886 (1/17)
Implementation Date Requested:	01/01/2017
Author(s):	Esther Drew
Reviewer(s):	Colin Johnson (primary)
Disposition Date:	
Disposition Status:	
Implementation Date:	

State: *District of Columbia* **Filing Company:** *UnitedHealthcare Insurance Company*
TOI/Sub-TOI: *H21 Health - Other/H21.000 Health - Other*
Product Name: *2017 Railroad COC Filing*
Project Name/Number: */*

General Information

Project Name:
Project Number:
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Group Market Type: Employer
Filing Status Changed: 11/14/2016
State Status Changed:
Created By: Esther Drew
Corresponding Filing Tracking Number:

Status of Filing in Domicile: Not Filed
Date Approved in Domicile:
Domicile Status Comments:
Market Type: Group
Group Market Size: Large
Overall Rate Impact:

Deemer Date:
Submitted By: Esther Drew

PPACA: Not PPACA-Related

PPACA Notes: null

Include Exchange Intentions: No

Filing Description:

On behalf of UnitedHealthcare Insurance Company. I am submitting the enclosed certificate of coverage filing for your Department's review and approval.

This is an employee pay all plan designed to cover certain railroad employees and their dependents when their group health coverage under their employer-sponsored plans ends. If a former employee is not Medicare eligible, they can enroll in Plans A, B, or C. Plan F is for those who are Medicare eligible, and is similar to a Medicare Supplement Plan in that it provides coverage for certain benefits that may not be covered under Medicare or provides coverage beyond what is payable by Medicare. Plans E is only for those former employees who are also eligible for another railroad retiree plan - The Railroad Employees National Early Retirement Major Medical Benefit Plan (GA-46000). Plan M is only for former employees who were covered under the Keolis Commuter Services (formerly Massachusetts Bay Commuter Rail) Plan. Plan P is only for former employees of Amtrak or TransitAmerica, Inc. (TASI).

I have provided a clean copy of the new Certificate that as well as a redline version of the previously filed plan that was approved by your Department in 2015 under SERFF # UHLC-130022785, Form No. 50086886 (3/15). Most of the changes are corrections or the addition of information. The customer has directed us that the plan should now be an ERISA plan, so things like COBRA, Appeals, Information Required by ERISA, and Non-Discrimination Notice, have all been added.

Company and Contact

Filing Contact Information

Esther Drew,
48 Monroe Turnpike
Trumbull,, CT 06611

esther_l_drew@uhc.com
203-459-7093 [Phone]

State: *District of Columbia*
TOI/Sub-TOI: *H21 Health - Other/H21.000 Health - Other*
Product Name: *2017 Railroad COC Filing*
Project Name/Number: */*
Filing Company: *UnitedHealthcare Insurance Company*

Filing Company Information

UnitedHealthcare Insurance Company
185 Asylum Street
Hartford, CT 06103
(860) 702-5000 ext. [Phone]

CoCode: 79413
Group Code: 707
Group Name:
FEIN Number: 36-2739571

State of Domicile: Connecticut
Company Type: Life and Health
State ID Number: 79413

Filing Fees

Fee Required? No
Retaliatory? No
Fee Explanation:

SERFF Tracking #:	*UHLC-130805292*	***State Tracking #:***		***Company Tracking #:***	*50086886 (1/17)*

State:	*District of Columbia*	***Filing Company:***	*UnitedHealthcare Insurance Company*
TOI/Sub-TOI:	*H21 Health - Other/H21.000 Health - Other*		
Product Name:	*2017 Railroad COC Filing*		
Project Name/Number:	*/*		

Form Schedule

Lead Form Number: 50086886 (1/17)

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1		Certificate of Coverage	50086886 (1/17)	CER	Initial		50.300	50086886_1.17.pdf

Form Type Legend:

ADV	Advertising	**AEF**	Application/Enrollment Form
CER	Certificate	**CERA**	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	**FND**	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	**NOC**	Notice of Coverage
OTH	Other	**OUT**	Outline of Coverage
PJK	Policy Jacket	**POL**	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	**SCH**	Schedule Pages

CERTIFICATE OF COVERAGE

for inactive railroad and union Employees and their Dependents who are eligible for Health Benefits Plans offered by:

COOPERATING RAILWAY LABOR ORGANIZATIONS

(called the Policyholder)

insured by

UNITEDHEALTHCARE INSURANCE COMPANY
Hartford, Connecticut
(called the Company)

UnitedHealthcare Insurance Company has issued Group Policy No GA-23111 to the Policyholder, Cooperating Railway Labor Organizations, consisting of the separate organizations shown on page 2 of this Certificate. The Policy covers retired railroad workers as provided through collective bargaining agreements established by the signatories to the Policy as listed on page 2.

This Certificate of Coverage describes the benefits and provisions of the Policy.

This is an Employee's Certificate of Coverage only while that Employee is insured under the Policy. Dependent benefits apply only if the inactive railroad or union Employee is insured under this Plan for Dependent benefits.

This Certificate describes the Plans in effect as of [January 1, 2017]. It is void if issued to any other Employee.

This Certificate replaces any and all Certificates previously issued for this Policy.

UNITEDHEALTHCARE INSURANCE COMPANY

[Jeffrey Alter, President]

[50086886 (1/17)]

THE GROUP HEALTH PLANS DESCRIBED IN THIS CERTIFICATE OF COVERAGE ARE AVAILABLE TO INACTIVE EMPLOYEES OF, OR REPRESENTED BY THE FOLLOWING COOPERATING RAILWAY LABOR ORGANIZATIONS SIGNATORY TO GROUP HEALTH POLICY GA-23111

[International Brotherhood of Boilermakers, Iron Ship Builders, Blacksmiths, Forgers and Helpers

International Brotherhood of Electrical Workers

National Conference of Firemen and Oilers/SEIU

International Association of Machinists and Aerospace Workers

SMART Mechanical Department

Transportation Communications Union/IAM

Brotherhood of Maintenance of Way Employes Division/IBT

Brotherhood of Railroad Signalmen

Brotherhood of Locomotive Engineers and Trainmen Division/IBT

SMART Transportation Division

American Train Dispatchers Association

Transport Workers Union]

THE PLANS ARE ALSO AVAILABLE TO CERTAIN EMPLOYEES REPRESENTED BY OTHER ORGANIZATIONS.

Table of Contents

INTRODUCTION

The Plans included in this Certificate have been made available by the Railway Labor Organizations to provide benefits under Group Policy GA-23111 for Employees and Dependents formerly covered under the Railroad Employees National Health and Welfare Plan, the NRC/UTU Plan, GA-46000, GA-107300, the Amtrak Early Retirement Plan, the Keolis Commuter Services (formerly Massachusetts Bay Commuter Railroad MBCR) Early Retirement Plan, or the TransitAmerica Services, Inc. (TASI) Early Retirement Plan, and for parents of Employees currently covered under one of these plans.

Some of the terms used in this Certificate need explanation because they have specialized or important meanings for the purposes of the Group Policy. When any of these terms is used in this Certificate, it will have the meaning shown for that term in the Definitions section of this Certificate of Coverage. Refer to this section whenever you have a question about any of the terms listed below.

Alternate Care Plan

Ambulatory Surgical Center

Amtrak Early Retirement Plan

Assistant Surgeon Services

Birth Center

Chemotherapy

COBRA

Convenient Care Clinic

Covered Health Services

Custodial Care

Dependent

Durable Medical Equipment

Employee

Experimental or Investigational or Unproven Service(s)

Full Medicare Coverage

Furloughed Employee

GA-107300

GA-46000

Home Health Care Agency

Hospice

Hospital

Inactive Employee

Keolis Commuter Services (formerly MBCR) Early Retirement Plan

Level of Care

Medical Judgment

Medically Appropriate

Medicare

Multiple Surgical Procedures

Nurse-Midwife

NRC/UTU Plan

Person Eligible Under Medicare

Physician

Policy

Policyholder

Preferred Providers

Psychologist

Railroad Employees National Health and Welfare Plan

Reasonable Charge

Skilled Nursing Facility

Student

TransitAmerica Services, Inc. (TASI) Early Retirement Plan

Transplant Facility

Treatment Center

Urgent Care Center

Whenever the pronouns "he", "his", or "him" appear in this text, they refer equally to the female as well as the male gender.

II
SUMMARY OF THE GROUP POLICY

The benefits described in this Certificate are for U.S. residents only. Here is a brief summary of the eligibility and benefit provisions of Group Policy GA-23111. The detailed description of these provisions is contained later in this Certificate of Coverage.

ELIGIBILITY SUMMARY

When your coverage under the Railroad Employees National Health and Welfare Plan, the NRC/UTU Plan, GA-46000, GA-107300, the Amtrak Early Retirement Plan, the Keolis Commuter Services (formerly MBCR) Early Retirement Plan, or the TransitAmerica Services, Inc. (TASI) Early Retirement Plan terminates, you may enroll in Plan A, B, C, E, F, M or P for yourself and/or your Dependents in accordance with the following:

Plans A, B and C are for all persons eligible for coverage under GA-23111 except Persons Eligible Under Medicare, and persons eligible under GA-46000 the Amtrak Early Retirment Plan, the Keolis Commuter Services (formerly MBCR) Early Retirement Plan or the TransitAmerica Services, Inc. (TASI) Early Retirement Plan.

Plan E is for persons eligible under GA-46000 or any other group health plan which is determined by UnitedHealthcare Insurance Company to provide benefits identical to GA-46000.

Plan F is for Persons Eligible Under Medicare. Each person must be enrolled separately and a separate premium paid under Plan F.

Plan M is for persons eligible under the Keolis Commuter Services (formerly MBCR) Early Retirement Plan.

Plan P is for persons eligible under the Amtrak Early Retirement Plan, the TransitAmerica Services, Inc. (TASI) Early Retirement Plan or any other group health plan which is determined by UnitedHealthcare Insurance Company to provide benefits identical to the Amtrak Early Retirement Plan.

BENEFITS SUMMARY – PLANS A, B AND C

Benefit	Policy GA-23111		
	Plan A	**Plan B**	**Plan C**
Annual Deductible (applies to OOP deductible)	[$500 – 3,000]	[$500 – 3,000]	[$500 – 3,000]
Annual Out of Pocket Maximum	[$5,000 – 30,000]	[$5,000 – 30,000]	[$5,000 – 30,000]
Policy Lifetime Maximum Benefit	[$200,000 - unlimited]	[$200,000 - unlimited]	[$200,000 - unlimited]
Inpatient Hospital and Related Services (includes maternity) **Inpatient Mental Health and Substance Abuse Services** **Surgical Procedures (Surgeon, Anesthesiology and Facility, including Ambulatory Surgical Center and Outpatient Surgical Center)**	[40 - 60]% of eligible expenses after satisfying deductible.	[50 - 70]% of eligible expenses after satisfying deductible.	[60 - 80]% of eligible expenses after satisfying deductible.
Medical Services/ Physician's Office Visit	[40 - 60]% of eligible expenses after satisfying deductible. 100% of eligible expenses without coinsurance or deductible for the following: Mammography and Pap Smear.	[50 - 70]% of eligible expenses after satisfying deductible. 100% of eligible expenses without coinsurance or deductible for the following: Mammography and Pap Smear.	[60 - 80]% of eligible expenses after satisfying deductible. 100% of eligible expenses without coinsurance or deductible for the following: Mammography and Pap Smear.
Outpatient Mental Health and Substance Abuse services	75% of eligible expenses after satisfying deductible for the first 40 visits, 60% for any visits thereafter.	75% of eligible expenses after satisfying deductible for the first 40 visits, 60% for any visits thereafter.	75% of eligible expenses after satisfying deductible for the first 40 visits, 60% for any visits thereafter.
Outpatient Rehabilitation (physical, occupational, speech therapy and Chiro)	[40 - 60]% of eligible expenses after satisfying deductible. *Limited to 30 visits per calendar year. Exception: Calendar year visit limit does not apply to services for a child under age 21 with a congenital or birth defect.	[50 - 70]% of eligible expenses after satisfying deductible. *Limited to 30 visits per calendar year. Exception: Calendar year visit limit does not apply to services for a child under age 21 with a congenital or birth defect.	[60 - 80]% of eligible expenses after satisfying deductible. *Limited to 30 visits per calendar year. Exception: Calendar year visit limit does not apply to services for a child under age 21 with a congenital or birth defect.
Allergy/Acupuncture Services	[40 - 60]% of eligible expenses after satisfying deductible.	[50 - 70]% of eligible expenses after satisfying deductible.	[60 - 80]% of eligible expenses after satisfying deductible.

Benefit	Policy GA-23111		
	Plan A	**Plan B**	**Plan C**
Emergency Room Services	[40 - 60]% of eligible expenses after satisfying deductible.	[50 - 70]% of eligible expenses after satisfying deductible.	[60 – 80]% of eligible expenses after satisfying deductible.
Durable Medical Equipment Prior notification is required for items over $1,000.*	[40 - 60]% of eligible expenses after satisfying deductible.	[50 - 70]% of eligible expenses after satisfying deductible.	[60 - 80]% of eligible expenses after satisfying deductible.
Prescription Drugs	Not Covered	Not Covered	Not Covered
Home Health Care Services*	[40 - 60]% of eligible expenses after satisfying deductible up to 30 visits per calendar year.	[50 - 70]% of eligible expenses after satisfying deductible up to 30 visits per calendar year.	[60 - 80]% of eligible expenses after satisfying deductible up to 30 visits per calendar year.
Hospice Facility*	[40 - 60]% of eligible expenses after satisfying deductible for up to a period of six (6) months.	[50 - 70]% of eligible expenses after satisfying deductible for up to a period of six (6) months.	[60 - 80]% of eligible expenses after satisfying deductible for up to a period of six (6) months.
Skilled Nursing Facility	[40 - 60]% of eligible expenses after satisfying deductible for up to [20-60] days per confinement; confinement applies to skilled nursing facility only.	[50 - 70]% of eligible expenses after satisfying deductible for up to [20-60] days per confinement; confinement applies to skilled nursing facility only.	[60 - 80]% of eligible expenses after satisfying deductible for up to [20-60] days per confinement; confinement applies to skilled nursing facility only.
Emergency Transportation Services	[40 - 60]% of eligible expenses after satisfying deductible for ambulance service to a hospital in the event of an emergency.	[50 - 70]% of eligible expenses after satisfying deductible for ambulance service to a hospital in the event of an emergency	[60 - 80]% of eligible expenses after satisfying deductible for ambulance service to a hospital in the event of an emergency.
Exclusions (partial list):	Hearing Wisdom Teeth Orthodontics Massage Therapy	Hearing Wisdom Teeth Orthodontics Massage Therapy	Hearing Wisdom Teeth Orthodontics Massage Therapy

** Requires prior notification – Care Coordination must be contacted to determine whether the purchase, rental of equipment or services provided are Medically Appropriate.*

PLAN A

Major Medical Expense Benefits

Maximum Amount per lifetime – [$200,000 - unlimited]

Cash Deductible per calendar year – [$500 - $3000]

Out-of-Pocket Maximum per calendar year – [$5,000 - $30,000]

Percentage of Covered Expenses payable – [40-60]% ([20-40]% if Care Coordination is not called when required).

Percentage of Covered Expenses payable after Out-of-Pocket Maximum is reached - 100% ([70-90]% if Care Coordination is not called when required)

PLAN B

Major Medical Expense Benefits

Maximum Amount per lifetime - [$200,000 - unlimited]

Cash Deductible per calendar year – [$500 - $3,000]

Out-of-Pocket Maximum per calendar year – [$5,000 - $30,000]

Percentage of Covered Expenses payable – [50-70]% ([30-50]% if Care Coordination is not called when required).

Percentage of Covered Expenses payable after Out-of-Pocket Maximum is reached - 100% ([70-90]% if Care Coordination is not called when required)

PLAN C

Major Medical Expense Benefits

Maximum Amount per lifetime – [$200,000 - unlimited]

Cash Deductible per calendar year – [$500 - $3,000]

Out-of-Pocket Maximum per calendar year – [$5,000 - $30,000]

Percentage of Covered Expenses payable – [60-80]% ([40-60]% if Care Coordination is not called when required).

Percentage of Covered Expenses payable after Out-of-Pocket Maximum is reached - 100% ([70-90]% if Care Coordination is not called when required)

PLAN F

Hospital Expense Benefits

For confinements up to 90 days:

- the Medicare Part A Deductible for the first 60 days;
- the Medicare Part A daily coinsurance amount for the 61st to the 90th day.

For confinements over 90 days:

- any Medicare Part A coinsurance amount when lifetime reserve days are used;
- up to 365 days of Hospital charges in a person's lifetime after all lifetime reserve days are used.

Skilled Nursing Facility Expense Benefits

The Medicare Part A daily coinsurance amount for the 21st to the 100th day of a Medicare approved confinement.

Medical Expense Benefits

The amount of the Medicare Part B deductible.

The amount of the Medicare Part B coinsurance.

The amount of the Medicare Part B limiting charge when a physician or provider does not accept a Medicare assignment.

The Medicare blood deductible.

Foreign Emergency Care Benefits

[80%] of charges for necessary emergency care in a foreign country up to a lifetime maximum of $[25,000 - $200,000].

At-Home Recovery Care Expense Benefits

Up to [$1,600] per year for short-term at-home assistance with activities of daily living for those recovering from an illness, injury or surgery.

Preventive Medical Care Expense Benefits

Up to [$100 - $2,000] per year for preventive screening tests or preventive services.

Treatment Center Expense Benefits

Confinements in a Treatment Center:

- 60 days per Calendar Year.
- 12 days per Calendar Year for detoxification services.

PLAN E / PLAN M / PLAN P

Major Medical Expense Benefits

Maximum Amount per lifetime – [$500,000 - $1,000,000]

Cash Deductible per calendar year – [$100 - $2500]

Out-of-Pocket Maximum per calendar year – [$5,000 - $30,000]

Percentage of Covered Expenses payable:

- All expenses except Outpatient Alcoholism, Chemical Dependency and/or Mental Illness Services - [60-80]%
- Expenses for Outpatient Alcoholism, Chemical Dependency and/or Mental Illness Services - 75% for the first 40 visits, 60% for any visits thereafter

Percentage of Covered Expenses payable after the Out-of-Pocket Maximum is reached - 100%

Treatment Center Expense Benefits

Confinements in a Treatment Center:

- 60 days per Calendar Year.
- 12 days per Calendar Year for detoxification services.

ALL PLANS

Under federal law, benefits may not be restricted for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, benefits may be paid for a shorter stay if the attending provider (e.g., your Physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

If the mother agrees, the attending provider may discharge the mother and/or newborn child earlier than these minimum time frames.

In all cases of early discharge, coverage shall be provided for post-delivery care within the minimum time periods shown above in the Employee's home, or, in a provider's office, as determined by the Physician in consultation with the mother.

The at-home post-delivery care shall be provided by a registered professional nurse, Physician, nurse-practitioner, nurse-midwife, or physician assistant experienced in maternal and child health, and shall include:

- parental education;
- assistance and training in breast or bottle feeding; and
- performance of any necessary and clinically appropriate tests, including the collection of an adequate sample for hereditary and metabolic newborn screening.

Additional benefits may be available to you or your Dependents depending on your state of residence. For more information contact [UnitedHealthcare, Railroad Administration, 450 Columbus Boulevard, P. O. Box 150476, Hartford, CT 06115-0476].

In addition, any provision of this Certificate which, on its effective date, is in conflict with the statutes of the jurisdiction in which you reside on such date, is hereby amended to conform to the minimum requirements of such statutes.

III
ENROLLMENT AND PAYMENT PROCEDURES

WHO MAY ENROLL

EMPLOYEES AND DEPENDENTS

GA-23111 enrollment is available to certain Employees and their Dependents, when their employer group health coverage ends. This employer group health coverage must have been provided under one of the following plans:

- Railroad Employees National Health and Welfare Plan;
- GA-46000;
- Amtrak Early Retirement Plan;
- Keolis Commuter Services (formerly MBCR) Early Retirement Plan;
- TransitAmerica Services, Inc. (TASI) Early Retirement Plan;
- GA-107300;
- NRC/UTU Plan; or
- Any other health and welfare plan established pursuant to an agreement between one or more railroads and one or more labor organizations.

GA-23111 is also available to former Railway Industry Employees, and their Dependents, who were not covered under one of the above listed plans, but who are members in accordance with the constitution or by-laws of one of the participating railway labor organizations, when coverage under the employer group health plan which applies to them ends.

If you live outside of the United States of America, you are not eligible for the coverage provided in this Certificate.

Important Message for Hospital Association Employees

If your Employee health benefits were provided by a hospital association while you were actively working, you may enroll for Employee benefits under GA-23111 only:

- If you are retired and do not qualify for benefits similar to GA-46000, the Amtrak Early Retirement Plan, the Keolis Commuter Services (formerly MBCR) Early Retirement Plan, or the TransitAmerica Services, Inc. (TASI) Early Retirement Plan through the hospital association, or
- If you are not retired, but are not actively at work, your membership in the hospital association is discontinued.

If you do qualify for benefits similar to GA-46000, the Amtrak Early Retirement Plan, the Keolis Commuter Services (formerly MBCR) Early Retirement Plan, or the TransitAmerica Services, Inc. (TASI) Early Retirement Plan through the hospital association, you can enroll for Employee benefits under GA-23111 when you become eligible for Medicare.

In the event Dependent benefits end under GA-107300 because a widow or a widower remarries, the surviving spouse, and any surviving dependent children, may enroll for Dependent benefits under GA-23111.

If you have questions about when your active group health coverage ends, please refer to the booklet titled The Railroad Employees National Health and Welfare Plan or the National Railway Carriers & United Transportation Union Health & Welfare Plan.

In order to determine when coverage ends under GA-46000 or GA-107300, refer to your benefits booklet for these plans, or call UnitedHealthcare at 1-800-842-5252.

In order to determine when coverage ends under the Amtrak Early Retirement Plan, the Keolis Commuter Services (formerly MBCR) Early Retirement Plan, or the TransitAmerica Services, Inc. (TASI) Early Retirement Plan, refer to the benefit booklet for those plans or call the number listed in those plans for more information.

In order to determine when your coverage under any other employer group health plan ends, refer to your benefits booklet, or call a representative of that plan.

If you are a Suspended or a Dismissed Employee enrolled under GA-23111, and if you are awarded full back pay for all time lost as a result of your suspension or dismissal, you may be entitled to a refund of the premiums you paid under GA-23111. If this occurs, you should contact UnitedHealthcare for additional information.

STUDENTS AND INCAPACITATED CHILDREN

Dependent benefits under Plans A, B, C, E and M cover children age 19 or over who are Students or who are incapacitated. Therefore if you are enrolling for Dependent benefits under Plans A, B, C, E or M, you are not required to enroll these children separately unless the child is eligible under Medicare. However, proof of Student or incapactitated status may be required. When incapacitated children are no longer eligible for Dependent benefits under Plans A, B, C, E or M, they must be enrolled separately, and an additional payment is required.

Dependent benefits under Plan P cover children through the end of the month in which they reach age 26, regardless of their student status. If you are enrolling for Dependent benefits under Plan P, you are not required to enroll these children separately unless the child is eligible under Medicare. Coverage for incapacitated children may continue beyond age 26 if the child's coverage is continued under the Amtrak Early Retirement Plan or the TransitAmerica Services, Inc. (TASI) Early Retirement Plan.

PARENTS OF EMPLOYEES COVERED UNDER THE RAILROAD EMPLOYEES NATIONAL HEALTH AND WELFARE PLAN, THE NRC/UTU PLAN, GA-46000, THE AMTRAK EARLY RETIREMENT PLAN, THE KEOLIS COMMUTER SERVICES (FORMERLY MBCR) EARLY RETIREMENT PLAN, THE TRANSITAMERICA SERVICES. INC. (TASI) EARLY RETIREMENT PLAN, GA-23111 AND GA-107300

Employees covered under the Railroad Employees National Health and Welfare Plan, the NRC/UTU Plan, GA-46000, the Amtrak Early Retirement Plan, the Keolis Commuter Services (formerly MBCR) Early Retirement Plan, the TransitAmerica Services, Inc. (TASI) Early Retirement Plan, GA-23111 or GA-107300 may enroll under Plan F to provide benefits for parents and parents-in-law who are eligible under Medicare.

WHEN TO ENROLL

There is an initial four month period during which you or your Dependents may enroll under GA-23111. This initial four month period begins in the month in which your employer group health coverage ends, and extends for the next three months. If you have questions about when your active group health coverage ends, please refer to your coverage document for your prior group health plan coverage.

If you did not enroll during your initial four month period, a second four month period is available when you or any individual Dependent first becomes eligible for Medicare. This second four month period begins in the month immediately prior to your Medicare eligibility date, and extends for the next three months.

Two examples may help explain these two enrollment periods:

1. If you are covered under the Railroad Employees National Health and Welfare Plan or the NRC/UTU Plan and you leave compensated service on [September 30, 2017] to retire, your Employee and Dependents health benefits under that plan would end [October 31, 2017]. Your initial four month period begins [October 1, 2017] and ends [January 31, 2018].

2. If you did not enroll under GA-23111 during your initial four month period, you have a second four month period beginning in the month prior to the month you become eligible for Medicare. If your Medicare eligibility date is [October 1, 2017], your second four month period begins [September 1, 2017] and ends [December 31, 2017]. If your spouse's Medicare eligibility date is [March 1, 2018], your spouse's second four month period begins [February 1, 2018] and ends [May 31, 2018].

If you or your Dependents are continuing your employer group health coverage under COBRA, your initial four month enrollment period begins in the month in which your COBRA continuation coverage ends.

If you are enrolling your parents or parents-in-law under GA-23111, there is only an initial four month enrollment period. It begins as follows:

- If your parent or parent-in-law is already eligible for Medicare when you first become covered under the Railroad Employees National Health and Welfare Plan, the NRC/UTU Plan, GA-46000, the Amtrak Early Retirement Plan, the Keolis Commuter Services (formerly MBCR) Early Retirement Plan, the TransitAmerica Services, Inc. (TASI) Early Retirement Plan, GA-23111 or GA-107300, your four month period begins in your first month of coverage.

- If your parent or parent-in-law becomes eligible for Medicare after you become covered under any of these plans, your four month period begins in the month prior to the month of your parent's or parent-in-law's Medicare eligibility date.

If you do not enroll during your initial or second four month enrollment period, you may enroll during a subsequent Open Enrollment Period.

SPECIAL ENROLLMENT PERIODS

You and/or your Dependents may be able to enroll during a special enrollment period, which is the first thirty (30) days immediately following a special enrollment event. A special enrollment period is not available to you or your Dependents if coverage under the prior plan was terminated for cause, or because premiums were not paid on a timely basis.

A special enrollment period applies to you and your Dependents when one of the following events occurs:

- Birth.
- Legal adoption of an eligible child or the placement of a child with you for adoption.
- Marriage.

A special enrollment period also applies for you or your Dependents who did not enroll under the Policy if the following are true:

- You or your Dependents had existing health coverage under another plan at the time you/they had an opportunity to enroll under the Policy; and
- Coverage under the prior plan ended because of any of the following:
    - Loss of eligibility (including, but not limited to, legal separation, divorce or death).
    - The employer stopped paying the contributions. This is true even if you or your Dependents continue to receive coverage under the prior plan and pay the amounts previously paid by the employer.
    - In the case of COBRA continuation coverage, the coverage ended.
    - You or your Dependents no longer live or work in an HMO service area if no other benefit option is available.
    - The plan no longer offers benefits to a class of individuals that include you and/or your Dependents.
    - You or your Dependents incur claims that would exceed a lifetime limit on all benefits.

When an event takes place (for example, a birth or marriage), coverage begins on the date of the event. For you and your Dependents who did not enroll under the Policy because you/they had existing health coverage under another plan, coverage begins on the day immediately following the day coverage under the prior plan ends.

You must notify UnitedHealthcare within thirty (30) days of the occurrence of any of the special enrollment events. If you do not notify UnitedHealthcare within that timeframe, you will not be able to enroll yourself or your Dependents under the Policy until the next Open Enrollment Period.

You will be responsible for any increase in your monthly premium due to the addition of a new Dependent to the Policy (i.e., going from employee only, to employee plus spouse, etc.)

IMPORTANT MESSAGE FOR PERSONS ELIGIBLE UNDER MEDICARE

No person may enroll under Plan F if that person is covered under any one of the programs called Medicare Advantage Plans (formerly called Medicare+Choice). These programs are described in the Medicare Handbook *Medicare & You*.

Any individual covered under Plan F who subsequently enrolls under any of the programs called Medicare Advantage cannot continue coverage under Plan F beyond the effective date of the individual's coverage under the Medicare Advantage plan. You must notify UnitedHealthcare if you become covered under a Medicare Advantage plan.

If you cancel coverage under any of the Medicare Advantage plans with a cancellation effective date of December 31, you may enroll under Plan F, with an effective date of January 1 of the following year. You may enroll in December or January for a January 1 effective date under these circumstances, provided you notify UnitedHealthcare within 30 days of your Medicare Advantage plan cancellation, you provide documentation that your coverage under that plan was cancelled, and you make the January payment for coverage under Plan F.

If you cancel your Medicare Advantage plan at any other point during a calendar year, you will only be able to enroll in Plan F during an Open Enrollment Period.

If you lose your Medicare Advantage coverage because the plan closes and you return to Medicare, you can enroll in Plan F provided you notify UnitedHealthcare within 30 days of the termination. You must provide documentation showing the plan closed to all individuals, such as a letter from the plan or a public notice of the closure in a newspaper.

OPEN ENROLLMENT PERIOD

An Open Enrollment Period is held [no less frequently than for a thirty day period in [month][in November and December] of each even calendar year ([2018, 2020], etc.), and there may be additional special enrollment periods. Enrollments during the Open Enrollment Period are for coverage beginning on the 1st day of the month following the end of the Open Enrollment Period.

HOW TO ENROLL

1. Fill out and sign the enrollment form. If you do not have an enrollment form, you can obtain one by calling UnitedHealthcare at 1-800-842-5252 or online on the Your Track to Health website at www.yourtracktohealth.com. Please be sure all employment information on the form is completed. In selecting the person(s) to be covered and the plan on the reverse side of the form, remember the following:

- Plans A, B and C are only available to Employees and Dependents who are not eligible under Medicare or GA-46000, the Amtrak Early Retirement, the Keolis Commuter Services (formerly MBCR) Early Retirement Plan, or the TransitAmerica Services, Inc. (TASI) Early Retirement Plan.
- Each Person Eligible Under Medicare may enroll in Plan F. This includes children who are eligible under Medicare. If your spouse is enrolled under Plan F, your Dependent children must be separately enrolled under Plans A, B or C in order to be covered under GA-23111.
- You must be covered under GA-46000 in order to be eligible under Plan E. Eligibility requirements for GA-46000 are described in the GA-46000 booklet. If you meet the eligibility requirements for GA-46000, but you or one of your Dependents is eligible for Medicare, you or that Dependent must enroll under Plan F in order to be covered under GA-23111.

- You must be covered under the Keolis Commuter Services (formerly MBCR) Early Retirement Plan in order to be eligible under Plan M. If you meet the eligibility requirements for the Keolis Commuter Services (formerly MBCR) Early Retirement Plan, but you or one of your Dependents is eligible for Medicare, you or that Dependent must enroll under Plan F in order to be covered under GA-23111.
- You must be covered under the Amtrak Early Retirement Plan or the TransitAmerica Services, Inc. (TASI) Early Retirement Plan in order to be eligible under Plan P. If you meet the eligibility requirements for the Amtrak Early Retirement Plan or the TransitAmerica Services, Inc. (TASI) Early Retirement Plan, but you or one of your Dependents is eligible for Medicare, you or that Dependent must enroll under Plan F in order to be covered under GA-23111.

3. Mail the completed enrollment form with check or money order in the amount required, as specified on the form, to UnitedHealthcare in accordance with the instructions on the enrollment form.

4. After you have enrolled for coverage **you must notify** UnitedHealthcare whenever:
   - One of your children reaches age 19 and qualifies as either a Student (under Plans A, B, C, E or M) or as an incapacitated child under any of the Plans.
   - You or one of your Dependents becomes eligible for Medicare due to disability or end stage renal disease.

   Coverage for each Person Eligible Under Medicare will not be continued under Plans A, B, C, E, M or P as of the date of Medicare eligibility. Coverage for such Employee or Dependent will be automatically transferred to Plan F at age 65.

   IMPORTANT: If you or your Dependent becomes eligible under Medicare before age 65, you **must** notify UnitedHealthcare and send a copy of your Medicare card so that continued coverage, if desired, can be transferred to Plan F.

5. If you return to compensated service, and you again become covered under an employer group health plan, you should:
   - Make no further premium payments under GA-23111.
   - Advise us of your return to work date, and the date your employer group health plan coverage becomes effective, by writing to UnitedHealthcare, Railroad Administration, 450 Columbus Boulevard, P. O. Box 150476, Hartford, CT 06115-0476.

EFFECTIVE DATE OF COVERAGE

If you enroll in the first or second month of your initial four month period, your GA-23111 coverage will be effective beginning on the day after your coverage under the employer group health plan ends. You will have no gap in coverage between plans.

If you enroll in the third or fourth month of your initial four month period, your GA-23111 coverage will be effective on the first day of the month following your enrollment. You will have a gap between the date your coverage under the employer group health plan ends, and the date your GA-23111 coverage begins.

If you enroll in the first or second month of your second four month period, your GA-23111 coverage will be effective on your Medicare effective date.

If you enroll in the third or fourth month of your second four month period, your GA-23111 coverage will be effective on the first day of the month following your enrollment.

If you are enrolling your parents or parents-in-law who are already eligible for Medicare when you first become covered under the Railroad Employees National Health and Welfare Plan, NRC/UTU Plan, GA-46000, the Amtrak Early Retirement Plan, the Keolis Commuter Services (formerly MBCR) Early Retirement Plan, the TransitAmerica Services, Inc. (TASI) Early Retirement Plan, GA-23111 or GA-107300, your GA-23111 coverage will always be effective on the first day of the month following your enrollment.

If you are enrolling your parents or parents-in-law who become eligible for Medicare after you become covered under the Railroad Employees National Health and Welfare Plan, NRC/UTU Plan, GA-46000, the Amtrak Early Retirement Plan, the Keolis Commuter Services (formerly MBCR) Early Retirement Plan, or the TransitAmerica Services, Inc. (TASI) Early Retirement Plan, GA-23111 or GA-107300, the rules stated above applicable to the second four month period will apply.

If you enroll during an Open Enrollment Period, your coverage will be effective on the first of the following month.

For the purposes of determining the effective date of GA-23111 coverage, your enrollment occurs when your completed Enrollment Form and payment is mailed (postmarked) to UnitedHealthcare.

For newborn coverage, benefits are payable for a newborn child for 31 days after the child's birth, even if the Employee has not enrolled the child. In order to cover the child beyond the 31 days, the Employee must enroll the child within those 31 days from the date of the birth.

PREMIUM PAYMENT PROCEDURES

Premiums under GA-23111 must be paid on a monthly basis.

You will be paying for coverage one month in advance. You will receive a "Notice of Payment Due" no later than the first week of each month. The payment is due by the 20th of that month, and will provide coverage for the following month.

With each "Notice of Payment Due" you will also receive a "Certification of Coverage-Payment Receipt." This form will acknowledge your previous payment and certify your coverage during the current month. It can be used as an identification card for hospitals and other providers of medical services.

If any monthly payment is not received by UnitedHealthcare by the due date shown on the "Notice of Payment Due," your next "Notice of Payment Due" will request payment for both the current month (which is past due) and the following month. If the past due amount is not paid, coverage will terminate as described in Termination of Coverage section.

You may choose to make your monthly payments via Electronic Funds Transfer (EFT) if you wish to have payments automatically deducted from your checking or savings account. Please contact UnitedHealthcare for further information on this option or visit the Your Track to Health website at www.yourtracktohealth.com for an Automatic Withdrawal / EFT Application.

TERMINATION OF COVERAGE

If you are billed monthly and do not pay any amount shown as past due, your coverage will terminate. You will **not** receive an additional notice. The termination will be effective as of the end of the last month for which payment has been received by UnitedHealthcare.

You may voluntarily terminate your coverage at any time by giving advanced notice in writing to UnitedHealthcare, P.O. Box 150476, Hartford, CT 06115-0476. Your termination will be effective on the first day of the month following the month in which your notice is received by UnitedHealthcare, unless your request clearly states a preferred advanced termination date.

OPTIONAL CONTINUATION OF HEALTH COVERAGE UNDER COBRA

This part of your Certificate contains important information about your right to **COBRA** continuation coverage, which is a temporary extension of coverage under the Plan. **The material in this section generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

The right to **COBRA** continuation coverage was created by a federal law, the Consolidated Omnibus Reconciliation Act of 1985 (**COBRA**). **COBRA** continuation coverage can become available to you when you would otherwise lose your coverage under the **Policy**. It can also become available to other members of your family who are covered under the **Policy** when they would otherwise lose their coverage under this **Policy**. What follows is only a summary of your **COBRA** continuation rights. For additional information about your rights and obligations under the **Policy** and under federal law, you should contact Railroad Enrollment Services toll free at 1-800-842-5252.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of **Policy** coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed below. After a qualifying event, **COBRA** continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the **Policy** is lost because of the qualifying event. Under the **Policy**, qualified beneficiaries who elect **COBRA** continuation coverage must pay for **COBRA** continuation coverage.

If you are the spouse of an **Employee**, you will become a qualified beneficiary if you lose your coverage under the **Policy** because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse becomes entitled to **Medicare** benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the **Policy** because any of the following qualifying events happens:

- The parent-**Employee** dies;
- The parent-**Employee** becomes entitled to **Medicare** (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the **Policy** as a "dependent child."

When is COBRA Coverage Available?

The **Policy** will offer **COBRA** continuation coverage to qualified beneficiaries only after Railroad Enrollment Services has been notified that a qualifying event has occurred.

You Must Give Notice of Qualifying Events

When there is a qualifying event (death of the Employee, the Employee becomes entitled to Medicare benefits (under Part A, Part B or both), divorce or legal separation of the Employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify Railroad Enrollment Services within 60 days after the qualifying event occurs. The notice must be in writing and must be sent to the following address:

Railroad Enrollment Services
Railroad Administration (COBRA)
P.O. Box 30791
Salt Lake City, UT 84130-0791

How is COBRA Coverage Provided?

Once Railroad Enrollment Services receives notice that a qualifying event has occurred, **COBRA** continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect **COBRA** continuation coverage. Covered **Employees** may elect **COBRA** continuation coverage on behalf for their spouses, and parents may elect **COBRA** continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of the coverage you lost as a result of the qualifying event. When the qualifying event is the death of the **Employee**, the **Employee's** becoming entitled to **Medicare** benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, **COBRA** continuation coverage lasts for up to a total of 36 months.

Disability Extension of 18-Month Period of Continuation Coverage

If you or anyone in your family covered under the **Policy** is determined by the Social Security Administration to be disabled, or has a total and permanent disability entitling him or her to an annuity under the Railroad Retirement Act, and you notify Railroad Enrollment Services of the determination within sixty (60) days from the date it was made, you and your entire family may be entitled to receive up to an additional 11 months of **COBRA** continuation coverage, for a total maximum of 29 months. The disability would have to have started at some point before the 60th day of **COBRA** continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

Second Qualifying Event Extension of 18-Month Period of Continuation Coverage

If your family experiences another qualifying event while receiving 18 months of **COBRA** continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of **COBRA** continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to Railroad Enrollment Services. This extension may be available to the spouse and any dependent children receiving continuation coverage if the **Employee** or former employee dies, becomes entitled to **Medicare** (Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the **Policy** as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the **Policy** had the first qualifying event not occurred.

If You Have Questions

Questions about your **Policy** or your **COBRA** continuation coverage rights should be addressed to Railroad Enrollment Services. For more information about your rights under ERISA, including **COBRA**, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.

Keep Railroad Enrollment Services Informed of Address Changes

In order to protect your family's rights, you should keep Railroad Enrollment Services informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to Railroad Enrollment Services.

IV

PLAN A

APPLICABLE TO PERSONS NOT ELIGIBLE UNDER MEDICARE, GA-46000, THE AMTRAK EARLY RETIREMENT MEDICAL PLAN, THE KEOLIS COMMUTER SERVICES (FORMERLY MBCR) EARLY RETIREMENT PLAN OR THE TRANSITAMERICA SERVICES, INC. (TASI) EARLY RETIREMENT PLAN

MAJOR MEDICAL EXPENSE BENEFITS

The Plan pays a percentage of Covered Expenses incurred in a calendar year which exceed the Deductible.

DEDUCTIBLE

The Deductible amount is [$500 - $3,000]. It applies separately to each covered individual each calendar year.

PERCENTAGE OF COVERED EXPENSES PAYABLE

The Plan pays [40% - 60%] (75% for the first 40 outpatient visits for alcoholism, chemical dependency and/or mental illness, and 60% for any visits thereafter) of the Covered Expenses in a calendar year after the Deductible is satisfied.

The Plan pays [20-40]% of the Covered Expenses in a calendar year after the Deductible is satisfied when Care Coordination is not called when required. See the Care Coordination description contained in this Section IV.

The Plan pays 100% of Covered Expenses in a calendar year after the Out-of-Pocket Maximum is met. ([70-90]% if Care Coordination is not called when required.)

OUT-OF-POCKET MAXIMUM

The Out-of-Pocket Maximum limits the amount of Covered Expenses you will have to pay for any one covered individual in a calendar year. The Out-of-Pocket Maximum is [$5,000 - $30,000] each calendar year. Covered Expenses used to satisfy your Deductible are also used to help satisfy your Out-of-Pocket Maximum.

The following expenses do not count in determining if any Out-of-Pocket Maximum has been met:

- Charges you pay that are in excess of the Reasonable Charge.
- Charges you pay that are in excess of specific Plan limits or exclusions.
- Charges you pay for expenses not covered by the Plan.
- [Charges you pay as a result of the reduction in benefits payable when Care Coordination is not notified or if the service or supply, although a Covered Health Service, is not Medically Appropriate.]

MAXIMUM AMOUNT

The Maximum Amount payable with respect to you or any of your Dependents is [$200,000 - unlimited]. The Maximum Amount applies to a person's entire lifetime and is a combined lifetime maximum under Plans A, B and C.

The Maximum Amount for anyone who has received benefits will be restored each January 1 by $1,000, or lesser amount, until the maximum is again [$200,000 - unlimited].

COVERED EXPENSES

Covered Expenses are the actual cost to you of the Reasonable Charges (see Definitions) for Covered Health Services (see Definitions) and supplies listed below. The service or supply must be needed because of injury, sickness or pregnancy.

A service or supply is not a Covered Health Service just because it is furnished by, or ordered by, your provider. The services and supplies will be reviewed by UnitedHealthcare to determine if they are considered Covered Health Services.

Acupuncture Services

Acupuncture services for the following conditions:

- Pain therapy, when another method of pain management has failed.
- Nausea that is related to surgery, pregnancy or chemotherapy.

Acupuncture services must be performed in an office setting by a provider who is one of the following, either practicing within the scope of his/her license (if state license is available) or who is certified by a national accrediting body:

- Doctor of Medicine
- Doctor of Osteopathy
- Acupuncturist
- Chiropractor
- Physician's Assistant

Allergy Immunotherapy Received in a Physician's Office

Benefits are available for allergy immunotherapy received in a Physician's office.

Ambulatory Surgical Center

Charges for services and supplies furnished in an Ambulatory Surgical Center in connection with a surgical procedure within 24 hours from and in connection with the surgical procedure.

Anesthetics

Applied Behavioral Analysis Services

Applied Behavioral Analysis (ABA) services for Autism Spectrum Disorders that are:

- Focused on the treatment of core deficits of Autism Spectrum Disorder;
- Provided by a *Board Certified Applied Behavioral Analyst (BCBA)* or other qualified provider under the appropriate supervision; and
- Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property, and impairment in daily functioning.

Services include the following:

- Diagnostic evaluations, assessment and treatment planning.
- Treatment and/or procedures.
- Medication management and other associated treatments.
- Individual, family, and group therapy.
- Provider-based case management services.
- Crisis intervention.

[Assistant Surgeon

Coverage for assistant surgeon services are limited to 1/5 of the amount of the Reasonable Charge for the surgeon's charge for the surgery. An assistant surgeon must be a Physician. Surgical assistant's services are covered at the same or lesser rate.]

Chemotherapy

Clinical Trials

Routine patient care costs incurred during participation in an approved clinical trial meeting the approved clinical trial criteria stated below.

Benefits include the reasonable and necessary items and services used to diagnose and treat complications arising from participation in an approved clinical trial.

Benefits are available only when the Covered Family Member is clinically eligible for participation in the clinical trial as defined by the researcher. Benefits are not available for preventive clinical trials.

Routine patient care costs for clinical trials include:

- Covered Health Services for which benefits are typically provided absent a clinical trial.
- Covered Health Services required solely for the provision of the investigational item or service, the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications.
- Covered Health Services needed for reasonable and necessary care arising from the provision of an investigational item or service.

Routine costs for clinical trials do not include:

- The Experimental or Investigational Service or item. The only exceptions to this are:
  - Certain Category B devices
  - Certain promising interventions for patients with terminal illnesses.
  - Other items and services that meet specified criteria in accordance with UnitedHealthcare's medical policy guidelines.
- Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.
- Items and services provided by the research sponsors free of charge for any person enrolled in the trial.

To be an approved clinical trial, a clinical trial must meet all of the following criteria:

- Be approved and funded in full or in part by one or more of the following:
  - National Institutes of Health (NIH). (Includes National Cancer Institute (NCI).)
  - Centers for Disease Control and Prevention (CDC).
  - Agency for Healthcare Research and Quality (AHRQ).
  - Centers for Medicare and Medicaid Services (CMS).
  - A bona fide clinical trial cooperative group, including the National Cancer Institute Clinical Trials Cooperative Group, the National Cancer Institute Community Clinical Oncology Program, the AIDS Clinical Trials Group, and the Community Programs for Clinical Research in AIDS.
  - The Department of Defense (DOD), the Department of Veterans Affairs, or the Department of Energy, or a qualified nongovernmental research entity to which the National Cancer Institute has awarded a support grant.
  - A study or investigation approved by the Food and Drug Administration (FDA), including those conducted under an investigational new drug or device application reviewed by the FDA.
  - An investigation or study approved by an Institutional Review Board registered with the Department of Health and Human Services that is associated with an institution that has a federal-wide assurance approved by the Department of Health and Human Services specifying compliance with federal regulations.
- The clinical trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (IRBs) before participants are enrolled in the trial. We may, at any time, request documentation about the trial to confirm that the clinical trial meets current standards for scientific merit and has the relevant IRB approvals.

The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Service and is not otherwise excluded under the Policy.

Convenient Care Clinic

Diabetes Treatment

Coverage for diabetic equipment, diabetes supplies and in-person outpatient diabetic self-management training and education programs (including medical nutrition therapy) when provided under the direction of a Physician by a certified, registered or licensed health care professional.

Diabetes self-management training includes training provided to a Covered Person after the initial diagnosis in the care and management of that condition, including nutritional counseling and proper use of diabetes equipment and supplies. Coverage is also provided for additional training upon diagnosis of a significant change in medical condition that requires a change in the self-management regime, and a periodic continuing education training as warranted by the development of new techniques and treatment for diabetes.

Durable Medical Equipment

Durable Medical Equipment that meets each of the following criteria:

- Ordered or provided by a Physician for outpatient use primarily in a home setting.
- Used for medical purposes.
- Not consumable or disposable except as needed for the effective use of covered Durable Medical Equipment.
- Not of use to a person in the absence of a disease or disability.

Examples of Durable Medical Equipment include:

- Equipment to assist mobility, such as a standard wheelchair.
- A standard Hospital-type bed. Non-hospital beds, comfort beds, and motorized beds/mattresses are generally excluded from coverage.
- Oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks).
- Delivery pumps for tube feedings (including tubing and connectors).
- Braces, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are considered Durable Medical Equipment and are a Covered Health Service. Braces that straighten or change the shape of a body part are orthotic devices, and are excluded from coverage. Dental braces are also excluded from coverage.
- Mechanical equipment necessary for the treatment of chronic or acute respiratory failure (air-conditioners, humidifiers, dehumidifiers, air purifiers and filters, and personal comfort items are excluded from coverage).
- Burn garments.
- Insulin pumps and all related necessary supplies.
- Wigs, but only for loss of hair resulting from treatment of a malignancy or permanent loss of hair from an accidental injury, and up to a maximum of [$500 per calendar year].
- Speech aid prosthetics and traceo-esophaeal voice prosthetics. All other devices and computers to assist in communication and speech are not considered Durable Medical Equipment.
- External prosthetic devices that replace a limb or body part.

Benefits under this section do not include:

- Durable Medical Equipment provided to you by a Physician.
- Generally, any device, appliance, pump, machine stimulator, or monitor that is fully implanted into the body.

If you have any questions regarding whether a particular item is considered to be Durable Medical Equipment, please contact Care Coordination.

Care Coordination must be contacted for any purchase or rental of Durable Medical Equipment that exceeds [$1,000]. UnitedHealthcare will decide if the equipment should be purchased or rented.

Benefits that are available for repairs and replacement, except that:

- Benefits for repair and replacement do not apply to damage due to misuse, malicious breakage or gross neglect.
- Benefits are not available to replace lost or stolen items.
- Replacement of Durable Medical Equipment is limited to every three years, unless there are catastrophic circumstances, in which case you should notify UnitedHealthcare and an individual case evaluation will be performed.

If more than one piece of Durable Medical Equipment can meet your functional needs, benefits are available only for the equipment that meets the minimum specifications for your needs. If you rent or purchase a piece of Durable Medical Equipment that exceeds this guideline, you will be responsible for any cost difference between the piece you rent or purchase and the piece that UnitedHealthcare has determined is the most cost-effective.

Emergency Transportation Services

Transportation charges are covered for transportation to a Hospital in connection with an emergency.

The transportation services must be to a Hospital in your local area. If there are no local Hospitals that can provide the care needed, charges for transportation to the nearest Hospital outside your local area qualified to give the required treatment, will be covered.

Habilitative Services

Habilitative Services for children from birth to age 21 are covered, except for Habilitative Services provided in early intervention and school services.

Habilitative Services includes services, including occupational therapy, physical therapy, and speech therapy, for the treatment of a child with a congenital or genetic birth defect to enhance the child's ability to function. For purposes of Habilitaitive Services, a cogenital or genetic birth defect means a defect existing at or from birth, including a hereditary defect. A congential or genetic birth defect includes, but is not limited to (a) autism or autism spectrum disorder, and (b) cerebral palsy.

Home Health Care Agency Services

Charges for services of a Home Health Care Agency prescribed in writing by a Physician to be in lieu of Hospital confinement, up to a maximum of 30 visits during any one calendar year. Each visit by a member of a home health care team will be considered as one home health care visit. Four hours of home health care services will be considered as one home health care visit. If a visit exceeds four hours, each additional four hours, or part thereof, will count as one additional visit. Each visit by any other member of the home health care team will count as an additional visit.

The following services and supplies of a Home Health Care Agency are covered:

- Temporary or part-time nursing care by or supervised by a registered graduate nurse (R.N.).
- Temporary or part-time care by a home health aide.
- Physical therapy, occupational therapy or speech therapy.
- Medical supplies.
- Drugs and medications ordered by a Physician.
- X-ray and laboratory tests.

Hospice

Hospice care that is recommended by a Physician, for a period of up to six (6) months. Hospice care is an integrated program that provides comfort and support services for the terminally ill. Hospice care includes physical, psychological, social and spiritual care for the terminally ill person and short-term grief counseling for immediate family members while the patient is receiving hospice care.

You must notify and receive approval from Care Coordination prior to receiving any inpatient or outpatient hospice care in order to be eligible for this benefit.

Benefits are available when hospice care is received from a licensed hospice agency.

A Physician must certify that the patient is terminally ill and that the patient's life expectancy is six (6) months or less.

Hospital Services

Services and supplies provided by a Hospital on an inpatient basis, except that if charges are made for a private room, Covered Expenses will be limited to the hospital's average daily charge for a semi-private room.

Coverage is provided for up to 60 inpatient days per calendar year for alcoholism, chemical dependency and/or mental illness services. In addition, coverage is provided for up to 12 days per calendar year for inpatient detoxification services.

Coverage is also provided for newborn infant hearing screenings and all necessary audiological examinations provided as recommended by the national Joint Committee on Infant Hearing. For purposes of this coverage, "Hospital" shall include birthing centers or other centers having newborn nurseries.

Services and supplies provided by a Hospital on an outpatient basis including:

- Emergency care and treatment for a medical emergency, including the sudden onset or worsening of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent lay person, who possesses an average knowledge of health and medicine to result in:
  - Placing the patient's health in serious jeopardy;
  - Serious impairment to bodily functions; or
  - Serious dsyfunction of any bodily organ or part.
- Voluntary HIV screening test performed while receiving emergency care in a Hospital, once per calendar year, regardless of whether or not the HIV screening test is necessary for the treatment of the condition for which the emergency care is sought.

Medical Supplies

- Medical and surgical supplies (such as bandages and dressings). Supplies given during surgery or a diagnostic procedure are included in the overall cost for that surgery or diagnostic procedure.
- Blood or blood derivatives only if not donated or replaced.

Multiple Surgical Procedures

When more than one surgical procedure is performed during the same operative session, Covered Expenses are limited as follows:

- Covered Expenses for the second procedure will be limited to 50% of the Reasonable Charge for that procedure had it been performed alone.
- Covered Expenses for any subsequent procedure are limited to 50% of the Reasonable Charge for the subsequent procedures.

Organ/Tissue Transplants

- Donor Charges

  In the case of an organ or tissue transplant, no services or supplies for the donor are considered Covered Health Services unless the recipient is the Employee or his/her Dependent. If the recipient is not the Employee or his/her Dependent, no benefits are payable for donor charges.

  The search for bone marrow/stem cell from a donor who is not biologically related to the patient is not considered a Covered Health Service UNLESS the search is made in connection with a transplant procedure arranged by a Transplant Facility.

- Qualified Procedures

  If a qualified procedure, listed below, is Medically Appropriate and performed at a Transplant Facility, the "Medical Care and Treatment" and "Transportation and Lodging" provisions set forth below apply:

    - Heart transplants
    - Heart/lung transplants
    - Liver transplants
    - Kidney transplants
    - Pancreas transplants
    - Kidney/pancreas transplants
    - Bone marrow/stem cell transplants
    - Other transplant procedures when UnitedHealthcare determines that it is necessary to perform the procedure at a Treatment Facility.

  If a transplant, even if determined to be Medically Appropriate, is not performed at a Transplant Facility, there will be no benefit payable for the "Medical Care and Treatment" or the "Transportation and Lodging" provisions set forth below.

- Medical Care and Treatment
  - The following services provided in connection with the transplant are Covered Health Services:
    - Pre-transplant evaluation for one of the procedures listed above
    - Organ acquisition and procurement
    - Hospital and Physician fees
    - Transplant procedures
    - Follow-up care for a period up to one year after the transplant
    - Search for bone marrow/stem cell from a donor who is not biologically related to the patient. If a separate charge is made for a bone marrow/stem cell search, a maximum benefit of $25,000 is payable for all charges made in connection with the search.

- Transportation and Lodging

  Care Coordination will assist the patient and family with travel and lodging arrangements. Expenses for travel, lodging and meals for the transplant recipient and a companion are available under this Plan as follows:

  - Reasonable and necessary expenses for transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of the transplant for the purposes of an evaluation, the transplant procedure or necessary post-discharge follow-up.
  - Reasonable and necessary expenses for lodging and meals for the patient (while not confined) and one companion. Benefits are paid at a per diem rate of up to $50 for one person or up to $100 for two people.

  Travel and lodging expenses are only available if the transplant recipient resides more than 50 miles from the Transplant Facility.

  If the Dependent who is the patient is a minor child, the transportation expenses of two companions will be covered and lodging and meal expenses will be reimbursed up to the $100 per diem rate.

There is a combined overall lifetime maximum of $10,000 per Employee or Dependent for all transportation, lodging and meal expenses incurred by the transplant recipient and companion(s) and reimbursed under Plans A, B and C, combined, in connection with all transplant procedures.

Outpatient Alcoholism, Chemical Dependency and Mental Illness Services

Benefits for outpatient services to treat alcoholism, chemical dependency and/or mental illness. The Plan pays 75% of the Covered Expenses in a calendar year after the Deductible is satisfied for the first 40 outpatient visits for alcoholism, chemical dependency and/or mental illness, and then 60% of any additional visits.

Outpatient Rehabilitation

Short-term outpatient rehabilitation services, limited to:

- Physical therapy
- Occupational therapy
- Chiropractic treatment
- Speech therapy
- Pulmonary rehabilitation therapy
- Cardiac rehabilitation therapy

Rehabilitation services are limited to thirty (30) visits per calendar year for any combination of services.

Rehabilitation services must be performed by a Physician or by a licensed therapy provider. Benefits under this section include rehabilitation services provided in a Physician's office or on an outpatient basis at a Hospital.

We will pay benefits for speech therapy for the treatment of disorders of speech, language, voice, communication and auditory processing only when the disorder results from injury, stroke, cancer, congenital anomaly, or autism spectrum disorders.

Physician Services

Physician charges for professional services incurred:

- in a Physician's office;
- during a Hospital confinement;
- for the performance of a surgical operation; or
- in a Skilled Nursing Facility.

When determined to be a Covered Health Service, charges by an assistant surgeon are also covered under the plan.

Preventive Adult Health Services

- One routine physical examination per calendar year, subject to the calendar year Deductible.
- Necessary laboratory tests and/or immunizations, subject to the calendar year Deductible.
- Benefits are available for mammography testing that is consistent with the recommendations of governmental scientific agencies. Benefits for mammography testing are payable when mammography testing is performed as follows:
  - a baseline mammogram; and
  - follow-up mammograms on an annual basis.
- Pap smears are covered annually, or when it is determined by the attending physician that the test is necessary.

The preventive services listed above for mammography testing and pap smears are not subject to coinsurance or the calendar year Deductible.

- Colorectal cancer screenings are covered in compliance with the American Cancer Society colorectal cancer screenings guidelines.
- Prostate cancer screenings are covered in accordance with the latest screening guidelines used by the American Cancer Society.

Preventive Child Health Services

Benefits are available from birth to age 21 including:

- Coverage for injury or sickness, including the necessary care and treatment of medically diagnosed congenital defects, birth abnormalities, and prematurity; and

Coverage for preventive and primary care services, including physician examinations, measurements, sensory screening, neuropsychiatric evaluation, and development screening, which coverage shall include unlimited visits up to the age of 12 years, and 3 visits per year for minor children ages 12 years up to age 21 years of age. Preventive and primary care services shall also include, as recommended by the physician, hereditary and metabolic screening at birth, immunizations, urinalysis, tuberculin tests, and hematocrit, hemoglobin, and other appropriate blood tests, including tests to screen for sickle hemoglobinopathy.

Radiation Therapy

Skilled Nursing Facility

Services and supplies up to [20-60] days of confinement following each Hospital confinement per calendar year.

If charges are made for a private room, Covered Expenses will be limited to the facility's daily charge for a semi-private room.

Skilled nursing facility stays must be approved in advance by Care Coordination in order to be eligible for benefits.

Telehealth

Charges for services provided through telehealth rather than face-to-face consultation when the services can appropriately be provided through telehealth.

- "Telehealth" means the use of live, interactive audio and visual transmissions of a physician-patient encounter from one site to another using telecommunications technologies. They may include transmissions of real-time telecommunications or those transmitted by store-and-forward technology.

- Telemedicine services are medical services provided via interactive audio, video or other electronic media for the purpose of diagnosis, consultation, or treatment that do not involve direct, in-person patient contact.

Treatment Center Services

Charges for services at a Treatment Center when a Physician or Psychologist has certified an alcoholism or chemical dependency and has prescribed such services, up to a calendar year maximum of 60 days. In addition, detoxification services will be covered for up to 12 days annually.

Urgent Care Center Services

Charges for Covered Health Services received at an Urgent Care Center.

X-ray and Laboratory Tests

IMPORTANT: It should be noted that the Covered Expenses listed above do not include charges for drugs, private duty nursing, Physician's home visits, and some other services and supplies which are covered under the Railroad Employees National Health and Welfare Plan, NRC/UTU Plan, GA-46000, the Amtrak Early Retirement Plan, the Keolis Commuter Services (formerly MBCR) Early Retirement Plan, the TransitAmerica Services, Inc. (TASI) Early Retirement Plan or GA-107300.

PREFERRED PROVIDERS

UnitedHealthcare has arranged with certain health care providers to become Preferred Providers. These Preferred Providers have agreed to discount their charges for Covered Expenses.

If Preferred Providers are used, the amount of Covered Expenses for which you are responsible will generally be less than the amount owed if other providers had been used. The percentage of Covered Expenses payable remains the same whether or not Preferred Providers are used. However, because the Covered Expenses may be less when Preferred Providers are used, the portion that you owe will be less.

You will receive an Identification Card showing that you and/or your Dependents Covered under Plans A, B or C, are entitled to these discounts. This Identification Card must be shown every time health care services are given. This is how the provider knows that you and/or your Dependent is covered under a Preferred Provider plan. Otherwise, you could be billed for the provider's normal charge.

Call UnitedHealthcare at 1-800-842-5252 to inquire about or locate Preferred Providers in your area. You may also access Preferred Provider information online at myuhc.com.

Preferred Providers are responsible for filing your claims directly to UnitedHealthcare. You do not need to submit claims for Preferred Providers services or supplies.

You must submit claims for services and supplies rendered by other providers as described in the section entitled Claim Information.

If a Preferred Provider bills you for any part of the discount amount, call UnitedHealthcare at 1-800-842-5252 for assistance.

CARE COORDINATION

Care Coordination is designed to encourage an efficient system of care for you and your Dependent(s) by identifying possible unmet covered health needs. This may include admission counseling, inpatient care advocacy, and certain discharge planning and disease management activities. Care Coordination activities are not a substitute for the medical judgment of your Physician, however, and the ultimate decision as to what medical care you actually receive must be made by you and your Physician.

Care Coordination is triggered when UnitedHealthcare receives notification of an upcoming treatment or service. The notification process serves as a gateway to care coordination activities.

When to Notify Care Coordination

Care Coordination must be notified as soon as possible after you know that you require any of the services or supplies shown below:

- Inpatient admissions to a Hosptial or Skilled Nursing Facility
- Home health care
- Hospice care
- Durable medical equipment (over $1,000)
- Reconstructive procedures
- Dental services rendered as a result of an accident
- [Gender transformation surgery]

With regard to organ/tissue transplants, Care Coordination must be notified at least seven working days before the scheduled date of any of the following or as soon as reasonably possible:

- The evaluation of a transplant
- The donor search
- The organ procurement/tissue harvest
- The transplant procedure

For an in-patient confinement which is the result of an emergency, you (or your representative or Physician) must call Care Coordination within one day (excluding weekends and holidays) from the date the confinement begins.

You should notify Care Coordination promptly after you become aware that you are pregnant. You are required to give this notice, however, only if and when inpatient care for the mother or child is expected to continue beyond:

- 48 hours following a normal delivery; or
- 96 hours following a Caesarean section.

The notice you give must be given in sufficient time to allow UnitedHealthcare to complete a review of the matter before the services are rendered. In the absence of advance notice, UnitedHealthcare may not be able to complete its review and determine, before you incur expenses, if the service is a Covered Health Service, and if so, whether it is Medically Appropriate.

Remember: This notice obligation is your responsibility. It is not the responsibility of your Physician, your Hospital or any other provider.

How to Give the Required Notice

Notice should be given by telephone at 1-800-842-5252. You can call at any time, day or night. However, if you call outside of the normal hours of operation, you may leave a message with your telephone number on an answering machine, and your call will be returned within one working day.

What Happens After You Give the Required Notice?

UnitedHealthcare will review the services for which you have given notice and will determine whether they are Covered Health Services, and, if so, whether they are Medically Appropriate.

The ultimate decision on your medical care must be made by you and your Physician. Review by Care Coordination only determines whether the service or supply is a Covered Health Service, and if so, whether it is Medically Appropriate, solely for purposes of deciding what, if any, amounts are payable with respect to the service or supply under the Plan.

Effects on Benefits

- Benefits are reduced if you do not give the required notice or if UnitedHealthcare determines that the service or supply, although a Covered Health Services, is not Medically Appropriate. In either case, the benefit will be reduced from [40-60]% to [30-50]% of the benefits payable under the Plan. If you have satisfied your Out-of-Pocket Maximum, benefits will be reduced from 100% to [70-90]%.

- No benefits are payable if UnitedHealthcare determines that the service or supply is not a Covered Health Service.

If UnitedHealthcare determines that a service is not a Covered Health Service or is not Medically Appropriate, you or your Physician can appeal that determination. Please see the Claim Information section for a description of the appeal process.

Case Management Services

UnitedHealthcare also provides case management services. These services focus on severe illnesses and injuries which could result in long-term hospital confinements. UnitedHealthcare will determine whether case management services are appropriate in your case.

Through case management services, benefits for alternative treatment, which are otherwise not Covered Health Services, may be offered to you or your Dependent when it is appropriate and cost effective. The decision to accept alternative treatment rests with the patient and Physician.

Disease Management Services

UnitedHealthcare also provides disease management services. These programs focus on providing information about certain chronic medical conditions, such as heart failure, coronary artery disease, diabetes, or asthma, and the ways these conditions can be treated or managed. If you have been diagnosed with a chronic medical condition, UnitedHealthcare may contact you to discuss this program. Or you may call UnitedHealthcare at 1-800-842-5252 to learn whether you are eligible to participate in a program. Participation is voluntary, and there is no charge for these services.

Through disease management services, benefits for alternative treatment, which are otherwise not Covered Health Services, may be offered to you or your Dependent when it is appropriate and cost effective. The decision to accept alternative treatment rests with the patient and Physician.

Telephonic Access to Nurses and Counselors

UnitedHealthcare provides a toll-free telephone number that puts you in immedicate contact with a registered nurse any time, 24 hours a day, seven days a week. These nurses can provide health information for routine or urgent health concerns, such as a recent diagnosis, a minor sickness or injury, or other health-related topics. You can also listen to pre-recorded messages on a variety of medical topics.

This service is available to you and your Dependents at no charge. To use it, you can call UnitedHealthcare at 1-866-735-5685.

WELLNESS PROGRAMS

Healthy Weight Program

UnitedHealthcare provides a non-surgical approach to addressing weight and obesity through nutritional and activity guidance. You may receive free educational information on the web or through the mail and may even be called by a health coach who is a specialist in weight management. This health coach will be a resource to advise and help you manage your weight.

This program offers:

- on-line self-help tools: health assessment, exercise tracker, meal planner, calorie counter and educational content;
- education on weight management and self-care strategies;
- nutritional guidance and counseling by a health coach and registered dietician (if needed); and
- activity recommendations and encouragement by a health coach and exercise physiologist (if needed).

Participation is completely voluntary and without extra charge. If you would like to participate or would like additional information regarding the program, please call the number on the back of your ID card.

Tobacco Cessation Program

UnitedHealthcare provides a tobacco cessation program to help smokers withdraw from nicotine dependence. By participating in this program, you will receive educational materials through the mail and one-on-one telephone sessions with trained cessation specialists.

This program offers:

- a quit smoking kit that includes a cessation manual and quit aids designed to provide support through this program;
- toll-free telephone access to cessation specialists (you will receive five (5) coaching sessions and may place unlimited calls to the cessation specialists when you have a question); and
- medication recommendations, and/or free over-the-counter nicotine replacement therapies if you or your Dependent are over the age of 18.

Participation is completely voluntary and without extra charge. If you would like to participate or would like additional information regarding the program, please call the number on the back of your ID Card.

Health Assessment

You and your spouse are invited to learn more about your health and wellness at **myuhc.com** and are encouraged to participate in the online health assessment. The health assessment is an interactive questionnaire designed to help you identify your healthy habits as well as potential health risks.

Your health assessment is kept confidential. Completing the assessment will not impact your benefits or eligibility for benefits in any way.

To find the health assessment, log in to **myuhc.com**. After logging in, access your personalized *Health & Wellness* page and click the *Health Assessment* link. If you need any assistance with the online assessment, please call the number on the back of your ID card.

[Next Steps

Individuals that complete a health assessment and are identified with three or more high risk factors, will be provided with telephonic outbound coaching. Coaching will be provided for any/all of the following topics, as appropriate; participation is completely voluntary and without extra charge:

- exercise,
- blood pressure management;
- smoking cessation;
- nutrition;
- stress management;
- cholesterol management; and
- back care/ergonomics.]

V
PLAN B

APPLICABLE TO PERSONS NOT ELIGIBLE UNDER MEDICARE, GA-46000,THE AMTRAK EARLY RETIREMENT MEDICAL PLAN, THE KEOLIS COMMUTER SERVICES (FORMERLY MBCR) EARLY RETIREMENT PLAN, OR THE TRANSITAMERICA SERVICES, INC. (TASI) EARLY RETIREMENT PLAN

MAJOR MEDICAL EXPENSE BENEFITS

The Plan pays a percentage of Covered Expenses incurred in a calendar year which exceed the Deductible.

DEDUCTIBLE

The Deductible amount is [$500 - $3,000]. It applies separately to each covered individual each calendar year.

PERCENTAGE OF COVERED EXPENSES PAYABLE

The Plan pays [50% - 70%] (75% for the first 40 outpatient visits for alcoholism, chemical dependency and/or mental illness, and 60% for any visits thereafter) of the Covered Expenses in a calendar year after the Deductible is satisfied.

The Plan pays [30-50]% of the Covered Expenses in a calendar year after the Deductible is satisfied when Care Coordination is not called when required. See the Care Coordination description contained in this Section V.

The Plan pays 100% of Covered Expenses in a calendar year after the Out-of-Pocket Maximum is met. ([70-90]% if Care Coordination is not called when required.)

OUT-OF-POCKET MAXIMUM

The Out-of-Pocket Maximum limits the amount of Covered Expenses you will have to pay for any one covered individual in a calendar year. The Out-of-Pocket Maximum is [$5,000 - $30,000] each calendar year. Covered Expenses used to satisfy your Deductible are also used to help satisfy your Out-of-Pocket Maximum.

The following expenses do not count in determining if any Out-of-Pocket Maximum has been met:

- Charges you pay that are in excess of the Reasonable Charge.
- Charges you pay that are in excess of specific Plan limits or exclusions.
- Charges you pay for expenses not covered by the Plan.
- [Charges you pay as a result of the reduction in benefits payable when Care Coordination is not notified or if the service or supply, although a Covered Health Service, is not Medically Appropriate.]

MAXIMUM AMOUNT

The Maximum Amount payable with respect to you or any of your Dependents is [$200,000 - unlimited]. The Maximum Amount applies to a person's entire lifetime and is a combined lifetime maximum under Plans A, B and C.

The Maximum Amount for anyone who has received benefits will be restored each January 1 by $1,000, or lesser amount, until the maximum is again [$200,000 - unlimited].

COVERED EXPENSES

Covered Expenses are the actual cost to you of the Reasonable Charges (see Definitions) for Covered Health Services (see Definitions) and supplies listed below. The service or supply must be needed because of injury, sickness or pregnancy.

A service or supply is not a Covered Health Service just because it is furnished by, or ordered by, your provider. The services and supplies will be reviewed by UnitedHealthcare to determine if they are considered Covered Health Services.

Acupuncture Services

Acupuncture services for the following conditions:

- Pain therapy, when another method of pain management has failed.
- Nausea that is related to surgery, pregnancy or chemotherapy.

Acupuncture services must be performed in an office setting by a provider who is one of the following, either practicing within the scope of his/her license (if state license is available) or who is certified by a national accrediting body:

- Doctor of Medicine
- Doctor of Osteopathy
- Acupuncturist
- Chiropractor
- Physician's Assistant

Allergy Immunotherapy Received in a Physician's Office

Benefits are available for allergy immunotherapy received in a Physician's office.

Ambulatory Surgical Center

Charges for services and supplies furnished in an Ambulatory Surgical Center in connection with a surgical procedure within 24 hours from and in connection with the surgical procedure.

Anesthetics

Applied Behavioral Analysis Services

Applied Behavioral Analysis (ABA) services for Autism Spectrum Disorders that are:

- Focused on the treatment of core deficits of Autism Spectrum Disorder;
- Provided by a *Board Certified Applied Behavioral Analyst (BCBA)* or other qualified provider under the appropriate supervision; and
- Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property, and impairment in daily functioning.
- Services include the following:
- Diagnostic evaluations, assessment and treatment planning.
- Treatment and/or procedures.
- Medication management and other associated treatments.
- Individual, family, and group therapy.
- Provider-based case management services.
- Crisis intervention.

[Assistant Surgeon

Coverage for assistant surgeon services are limited to 1/5 of the amount of the Reasonable Charge for the surgeon's charge for the surgery. An assistant surgeon must be a Physician. Surgical assistant's services are covered at the same or lesser rate.]

Chemotherapy

Clinical Trials

Routine patient care costs incurred during participation in an approved clinical trial meeting the approved clinical trial criteria stated below.

Benefits include the reasonable and necessary items and services used to diagnose and treat complications arising from participation in an approved clinical trial.

Benefits are available only when the Covered Family Member is clinically eligible for participation in the clinical trial as defined by the researcher. Benefits are not available for preventive clinical trials.

Routine patient care costs for clinical trials include:

- Covered Health Services for which benefits are typically provided absent a clinical trial.
- Covered Health Services required solely for the provision of the investigational item or service, the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications.
- Covered Health Services needed for reasonable and necessary care arising from the provision of an investigational item or service.

Routine costs for clinical trials do not include:

- The Experimental or Investigational Service or item. The only exceptions to this are:
  - Certain Category B devices.
  - Certain promising interventions for patients with terminal illnesses.
  - Other items and services that meet specified criteria in accordance with our medical policy guidelines.
- Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.
- Items and services provided by the research sponsors free of charge for any person enrolled in the trial.

To be an approved clinical trial, a clinical trial must meet all of the following criteria:

- Be approved and funded in full or in part by one or more of the following:
  - National Institutes of Health (NIH). (Includes National Cancer Institute (NCI).)
  - Centers for Disease Control and Prevention (CDC).
  - Agency for Healthcare Research and Quality (AHRQ).
  - Centers for Medicare and Medicaid Services (CMS).
  - A bona fide clinical trial cooperative group, including the National Cancer Institute Clinical Trials Cooperative Group, the National Cancer Institute Community Clinical Oncology Program, the AIDS Clinical Trials Group, and the Community Programs for Clinical Research in AIDS.
  - The Department of Defense (DOD), the Department of Veterans Affairs, or the Department of Energy, or a qualified nongovernmental research entity to which the National Cancer Institute has awarded a support grant.
  - A study or investigation approved by the Food and Drug Administration (FDA), including those conducted under an investigational new drug or device application reviewed by the FDA.
  - An investigation or study approved by an Institutional Review Board registered with the Department of Health and Human Services that is associated with an institution that has a federal-wide assurance approved by the Department of Health and Human Services specifying compliance with federal regulations.
- The clinical trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (IRBs) before participants are enrolled in the trial. We may, at any time, request documentation about the trial to confirm that the clinical trial meets current standards for scientific merit and has the relevant IRB approvals.

The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Service and is not otherwise excluded under the Policy.

Convenient Care Clinic

Diabetes Treatment

Coverage for diabetic equipment, diabetes supplies and in-person outpatient diabetic self-management training and education programs (including medical nutrition therapy) when provided under the direction of a Physician by a certified, registered or licensed health care professional.

Diabetes self-management training includes training provided to a Covered Person after the initial diagnosis in the care and management of that condition, including nutritional counseling and proper use of diabetes equipment and supplies. Coverage is also provided for additional training upon diagnosis of a significant change in medical condition that requires a change in the self-management regime, and a periodic continuing education training as warranted by the development of new techniques and treatment for diabetes.

Durable Medical Equipment

Durable Medical Equipment that meets each of the following criteria:

- Ordered or provided by a Physician for outpatient use primarily in a home setting.
- Used for medical purposes.
- Not consumable or disposable except as needed for the effective use of covered Durable Medical Equipment.
- Not of use to a person in the absence of a disease or disability.

Examples of Durable Medical Equipment include:

- Equipment to assist mobility, such as a standard wheelchair.
- A standard Hospital-type bed. Non-hospital beds, comfort beds, and motorized beds/mattresses are generally excluded from coverage.
- Oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks).
- Delivery pumps for tube feedings (including tubing and connectors).
- Braces, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are considered Durable Medical Equipment and are a Covered Health Service. Braces that straighten or change the shape of a body part are orthotic devices, and are excluded from coverage. Dental braces are also excluded from coverage.
- Mechanical equipment necessary for the treatment of chronic or acute respiratory failure (air-conditioners, humidifiers, dehumidifiers, air purifiers and filters, and personal comfort items are excluded from coverage).
- Burn garments.
- Insulin pumps and all related necessary supplies.
- Wigs, but only for loss of hair resulting from treatment of a malignancy or permanent loss of hair from an accidental injury, and up to a maximum of [$500 per calendar year].
- Speech aid prosthetics and traceo-esophaeal voice prosthetics. All other devices and computers to assist in communication and speech are not considered Durable Medical Equipment.
- External prosthetic devices that replace a limb or body part.

Benefits under this section do not include:

- Durable Medical Equipment provided to you by a Physician.
- Generally, any device, appliance, pump, machine stimulator, or monitor that is fully implanted into the body.

If you have any questions regarding whether a particular item is considered to be Durable Medical Equipment, please contact Care Coordination.

Care Coordination must be contacted for any purchase or rental of Durable Medical Equipment that exceeds [$1,000]. UnitedHealthcare will decide if the equipment should be purchased or rented.

Benefits that are available for repairs and replacement, except that:

- Benefits for repair and replacement do not apply to damage due to misuse, malicious breakage or gross neglect.
- Benefits are not available to replace lost or stolen items.
- Replacement of Durable Medical Equipment is limited to every three years, unless there are catastrophic circumstances, in which case you should notify UnitedHealthcare and an individual case evaluation will be performed.

If more than one piece of Durable Medical Equipment can meet your functional needs, benefits are available only for the equipment that meets the minimum specifications for your needs. If you rent or purchase a piece of Durable Medical Equipment that exceeds this guideline, you will be responsible for any cost difference between the piece you rent or purchase and the piece that UnitedHealthcare has determined is the most cost-effective.

Emergency Transportation Services

Transportation charges are covered for transportation to a Hospital in connection with an emergency.

The transportation services must be to a Hospital in your local area. If there are no local Hospitals that can provide the care needed, charges for transportation to the nearest Hospital outside your local area qualified to give the required treatment, will be covered.

Habilitative Services

Habilitative Services for children from birth to age 21 are covered, except for Habilitative Services provided in early intervention and school services.

Habilitative Services includes services, including occupational therapy, physical therapy, and speech therapy, for the treatment of a child with a congenital or genetic birth defect to enhance the child's ability to function. For purposes of Habilitaitive Services, a cogenital or genetic birth defect means a defect existing at or from birth, including a hereditary defect. A congential or genetic birth defect includes, but is not limited to (a) autism or autism spectrum disorder, and (b) cerebral palsy.

Home Health Care Agency Services

Charges for services of a Home Health Care Agency prescribed in writing by a Physician to be in lieu of Hospital confinement, up to a maximum of 30 visits during any one calendar year. Each visit by a member of a home health care team will be considered as one home health care visit. Four hours of home health care services will be considered as one home health care visit. If a visit exceeds four hours, each additional four hours, or part thereof, will count as one additional visit. Each visit by any other member of the home health care team will count as an additional visit.

The following services and supplies of a Home Health Care Agency are covered:

- Temporary or part-time nursing care by or supervised by a registered graduate nurse (R.N.).
- Temporary or part-time care by a home health aide.
- Physical therapy, occupational therapy or speech therapy.
- Medical supplies.
- Drugs and medications ordered by a Physician.
- X-ray and laboratory tests.

Hospice

Hospice care that is recommended by a Physician, for a period of up to six (6) months. Hospice care is an integrated program that provides comfort and support services for the terminally ill. Hospice care includes physical, psychological, social and spiritual care for the terminally ill person and short-term grief counseling for immediate family members while the patient is receiving hospice care.

You must notify and receive approval from Care Coordination prior to receiving any inpatient or outpatient hospice care in order to be eligible for this benefit.

Benefits are available when hospice care is received from a licensed hospice agency.

A Physician must certify that the patient is terminally ill and that the patient's life expectancy is six (6) months or less.

Hospital Services

Services and supplies provided by a Hospital on an inpatient basis, except that if charges are made for a private room, Covered Expenses will be limited to the hospital's average daily charge for a semi-private room.

Coverage is provided for up to 60 inpatient days per calendar year for alcoholism, chemical dependency and/or mental illness services. In addition, coverage is provided for up to 12 days per calendar year for inpatient detoxification services.

Coverage is also provided for newborn infant hearing screenings and all necessary audiological examinations provided as recommended by the national Joint Committee on Infant Hearing. For purposes of this coverage, "Hospital" shall include birthing centers or other centers having newborn nurseries.

Services and supplies provided by a Hospital on an outpatient basis including:

- Emergency care and treatment for a medical emergency, including the sudden onset or worsening of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent lay person, who possesses an average knowledge of health and medicine to result in:
  - Placing the patient's health in serious jeopardy;
  - Serious impairment to bodily functions; or
  - Serious dsyfunction of any bodily organ or part.
- Voluntary HIV screening test performed while receiving emergency care in a Hospital, once per calendar year, regardless of whether or not the HIV screeming in necessary for the treatment of the condition for which the emergency care is sought..

Medical Supplies

- Medical and surgical supplies (such as bandages and dressings). Supplies given during surgery or a diagnostic procedure are included in the overall cost for that surgery or diagnostic procedure.
- Blood or blood derivatives only if not donated or replaced.

Multiple Surgical Procedures

When more than one surgical procedure is performed during the same operative session, Covered Expenses are limited as follows:

- Covered Expenses for the second procedure will be limited to 50% of the Reasonable Charge for that procedure had it been performed alone.
- Covered Expenses for any subsequent procedure are limited to 50% of the Reasonable Charge for the subsequent procedures.

Organ/Tissue Transplants

- Donor Charges

  In the case of an organ or tissue transplant, no services or supplies for the donor are considered Covered Health Services unless the recipient is the Employee or his/her Dependent. If the recipient is not the Employee or his/her Dependent, no benefits are payable for donor charges.

  The search for bone marrow/stem cell from a donor who is not biologically related to the patient is not considered a Covered Health Service UNLESS the search is made in connection with a transplant procedure arranged by a Transplant Facility.

- Qualified Procedures

  If a qualified procedure, listed below, is Medically Appropriate and performed at a Transplant Facility, the "Medical Care and Treatment" and "Transportation and Lodging" provisions set forth below apply:

    - Heart transplants
    - Heart/lung transplants
    - Liver transplants
    - Kidney transplants
    - Pancreas transplants
    - Kidney/pancreas transplants
    - Bone marrow/stem cell transplants
    - Other transplant procedures when UnitedHealthcare determines that it is necessary to perform the procedure at a Treatment Facility.

  If a transplant, even if determined to be Medically Appropriate, is not performed at a Transplant Facility, there will be no benefit payable for the "Medical Care and Treatment" or the "Transportation and Lodging" provisions set forth below.

- Medical Care and Treatment
  - The following services provided in connection with the transplant are Covered Health Services:
    - Pre-transplant evaluation for one of the procedures listed above
    - Organ acquisition and procurement
    - Hospital and Physician fees
    - Transplant procedures
    - Follow-up care for a period up to one year after the transplant
    - Search for bone marrow/stem cell from a donor who is not biologically related to the patient. If a separate charge is made for a bone marrow/stem cell search, a maximum benefit of $25,000 is payable for all charges made in connection with the search.

- Transportation and Lodging

  Care Coordination will assist the patient and family with travel and lodging arrangements. Expenses for travel, lodging and meals for the transplant recipient and a companion are available under this Plan as follows:

  - Reasonable and necessary expenses for transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of the transplant for the purposes of an evaluation, the transplant procedure or necessary post-discharge follow-up.
  - Reasonable and necessary expenses for lodging and meals for the patient (while not confined) and one companion. Benefits are paid at a per diem rate of up to $50 for one person or up to $100 for two people.

  Travel and lodging expenses are only available if the transplant recipient resides more than 50 miles from the Transplant Facility.

  If the Dependent who is the patient is a minor child, the transportation expenses of two companions will be covered and lodging and meal expenses will be reimbursed up to the $100 per diem rate.

There is a combined overall lifetime maximum of $10,000 per Employee or Dependent for all transportation, lodging and meal expenses incurred by the transplant recipient and companion(s) and reimbursed under Plans A, B and C, combined, in connection with all transplant procedures.

Outpatient Alcoholism, Chemical Dependency and Mental Illness Services

Benefits for outpatient services to treat alcoholism, chemical dependency and/or mental illness. The Plan pays 75% of the Covered Expenses in a calendar year after the Deductible is satisfied for the first 40 outpatient visits for alcoholism, chemical dependency and/or mental illness, and then 60% of any additional visits.

Outpatient Rehabilitation

Short-term outpatient rehabilitation services, limited to:

- Physical therapy
- Occupational therapy
- Chiropractic treatment
- Speech therapy
- Pulmonary rehabilitation therapy
- Cardiac rehabilitation therapy

Rehabilitation services are limited to thirty (30) visits per calendar year for any combination of services.

Rehabilitation services must be performed by a Physician or by a licensed therapy provider. Benefits under this section include rehabilitation services provided in a Physician's office or on an outpatient basis at a Hospital.

We will pay benefits for speech therapy for the treatment of disorders of speech, language, voice, communication and auditory processing only when the disorder results from injury, stroke, cancer, congenital anomaly, or autism spectrum disorders.

Physician Services

Physician charges for professional services incurred:

- in a Physician's office;
- during a Hospital confinement;
- for the performance of a surgical operation; or
- in a Skilled Nursing Facility.

When determined to be a Covered Health Service, charges by an assistant surgeon are also covered under the plan.

Preventive Adult Health Services

- One routine physical examination per calendar year, subject to the calendar year Deductible.
- Necessary laboratory tests and/or immunizations, subject to the calendar year Deductible.
- Benefits are available for mammography testing that is consistent with the recommendations of governmental scientific agencies. Benefits for mammography testing are payable when mammography testing is performed as follows:
  - a baseline mammogram; and
  - follow-up mammograms on an annual basis.
- Pap smears are covered annually, or when it is determined by the attending physician that the test is necessary.

The preventive services listed above for mammography testing and pap smears are not subject to coinsurance or the calendar year Deductible.

- Colorectal cancer screenings are covered in compliance with the American Cancer Society colorectal cancer screenings guidelines.
- Prostate cancer screenings are covered in accordance with the latest screening guidelines used by the American Cancer Society.

Preventive Child Health Services

Benefits are available from birth to age 21 including:

- Coverage for injury or sickness, including the necessary care and treatment of medically diagnosed congenital defects, birth abnormalities, and prematurity; and

Coverage for preventive and primary care services, including physician examinations, measurements, sensory screening, neuropsychiatric evaluation, and development screening, which coverage shall include unlimited visits up to the age of 12 years, and 3 visits per year for minor children ages 12 years up to age 21 years of age. Preventive and primary care services shall also include, as recommended by the physician, hereditary and metabolic screening at birth, immunizations, urinalysis, tuberculin tests, and hematocrit, hemoglobin, and other appropriate blood tests, including tests to screen for sickle hemoglobinopathy.

Radiation Therapy

Skilled Nursing Facility

Services and supplies up to [20-60] days of confinement following each Hospital confinement per calendar year.

If charges are made for a private room, Covered Expenses will be limited to the facility's daily charge for a semi-private room.

Skilled nursing facility stays must be approved in advance by Care Coordination in order to be eligible for benefits.

Telehealth

Charges for services provided through telehealth rather than face-to-face consultation when the services can appropriately be provided through telehealth.

- "Telehealth" means the use of live, interactive audio and visual transmissions of a physician-patient encounter from one site to another using telecommunications technologies. They may include transmissions of real-time telecommunications or those transmitted by store-and-forward technology.

- Telemedicine services are medical services provided via interactive audio, video or other electronic media for the purpose of diagnosis, consultation, or treatment that do not involve direct, in-person patient contact.

Treatment Center Services

Charges for services at a Treatment Center when a Physician or Psychologist has certified an alcoholism or chemical dependency and has prescribed such services, up to a calendar year maximum of 60 days. In addition, detoxification services will be covered for up to 12 days annually.

Urgent Care Center Services

Charges for Covered Health Services received at an Urgent Care Center.

X-ray and Laboratory Tests

IMPORTANT: It should be noted that the Covered Expenses listed above do not include charges for drugs, private duty nursing, Physician's home visits, and some other services and supplies which are covered under the Railroad Employees National Health and Welfare Plan, NRC/UTU Plan, GA-46000, the Amtrak Early Retirement Plan, the Keolis Commuter Services (formerly MBCR) Early Retirement Plan, the TransitAmerica Services, Inc. (TASI) Early Retirement Plan or GA-107300.

PREFERRED PROVIDERS

UnitedHealthcare has arranged with certain health care providers to become Preferred Providers. These Preferred Providers have agreed to discount their charges for Covered Expenses.

If Preferred Providers are used, the amount of Covered Expenses for which you are responsible will generally be less than the amount owed if other providers had been used. The percentage of Covered Expenses payable remains the same whether or not Preferred Providers are used. However, because the Covered Expenses may be less when Preferred Providers are used, the portion that you owe will be less.

You will receive an Identification Card showing that you and/or your Dependents Covered under Plans A, B or C, are entitled to these discounts. This Identification Card must be shown every time health care services are given. This is how the provider knows that you and/or your Dependent is covered under a Preferred Provider plan. Otherwise, you could be billed for the provider's normal charge.

Call UnitedHealthcare at 1-800-842-5252 to inquire about or locate Preferred Providers in your area. You may also access Preferred Provider information online at myuhc.com.

Preferred Providers are responsible for filing your claims directly to UnitedHealthcare. You do not need to submit claims for Preferred Providers services or supplies.

You must submit claims for services and supplies rendered by other providers as described in the section entitled Claim Information.

If a Preferred Provider bills you for any part of the discount amount, call UnitedHealthcare at 1-800-842-5252 for assistance.

CARE COORDINATION

Care Coordination is designed to encourage an efficient system of care for you and your Dependent(s) by identifying possible unmet covered health needs. This may include admission counseling, inpatient care advocacy, and certain discharge planning and disease management activities. Care Coordination activities are not a substitute for the medical judgment of your Physician, however, and the ultimate decision as to what medical care you actually receive must be made by you and your Physician.

Care Coordination is triggered when UnitedHealthcare receives notification of an upcoming treatment or service. The notification process serves as a gateway to care coordination activities.

When to Notify Care Coordination

Care Coordination must be notified as soon as possible after you know that you require any of the services or supplies shown below:

- Inpatient admissions to a Hosptial or Skilled Nursing Facility
- Home health care
- Hospice care
- Durable medical equipment (over $1,000)
- Reconstructive procedures
- Dental services rendered as a result of an accident
- [Gender transformation surgery]

With regard to organ/tissue transplants, Care Coordination must be notified at least seven working days before the scheduled date of any of the following or as soon as reasonably possible:

- The evaluation of a transplant
- The donor search
- The organ procurement/tissue harvest
- The transplant procedure

For an in-patient confinement which is the result of an emergency, you (or your representative or Physician) must call Care Coordination within one day (excluding weekends and holidays) from the date the confinement begins.

You should notify Care Coordination promptly after you become aware that you are pregnant. You are required to give this notice, however, only if and when inpatient care for the mother or child is expected to continue beyond:

- 48 hours following a normal delivery; or
- 96 hours following a Caesarean section.

The notice you give must be given in sufficient time to allow UnitedHealthcare to complete a review of the matter before the services are rendered. In the absence of advance notice, UnitedHealthcare may not be able to complete its review and determine, before you incur expenses, if the service is a Covered Health Service, and if so, whether it is Medically Appropriate.

Remember: This notice obligation is your responsibility. It is not the responsibility of your Physician, your Hospital or any other provider.

How to Give the Required Notice

Notice should be given by telephone at 1-800-842-5252. You can call at any time, day or night. However, if you call outside of the normal hours of operation, you may leave a message with your telephone number on an answering machine, and your call will be returned within one working day.

What Happens After You Give the Required Notice?

UnitedHealthcare will review the services for which you have given notice and will determine whether they are Covered Health Services, and, if so, whether they are Medically Appropriate.

The ultimate decision on your medical care must be made by you and your Physician. Review by Care Coordination only determines whether the service or supply is a Covered Health Service, and if so, whether it is Medically Appropriate, solely for purposes of deciding what, if any, amounts are payable with respect to the service or supply under the Plan.

Effects on Benefits

- Benefits are reduced if you do not give the required notice or if UnitedHealthcare determines that the service or supply, although a Covered Health Services, is not Medically Appropriate. In either case, the benefit will be reduced from [60-80]% to [40-60]% of the benefits payable under the Plan. If you have satisfied your Out-of-Pocket Maximum, benefits will be reduced from 100% to [70-90]%.

- No benefits are payable if UnitedHealthcare determines that the service or supply is not a Covered Health Service.

If UnitedHealthcare determines that a service is not a Covered Health Service or is not Medically Appropriate, you or your Physician can appeal that determination. Please see the Claims Information section for a description of the appeal process.

Case Management Services

UnitedHealthcare also provides case management services. These services focus on severe illnesses and injuries which could result in long-term hospital confinements. UnitedHealthcare will determine whether case management services are appropriate in your case.

Through case management services, benefits for alternative treatment, which are otherwise not Covered Health Services, may be offered to you or your Dependent when it is appropriate and cost effective. The decision to accept alternative treatment rests with the patient and Physician.

Disease Management Services

UnitedHealthcare also provides disease management services. These programs focus on providing information about certain chronic medical conditions, such as heart failure, coronary artery disease, diabetes, or asthma, and the ways these conditions can be treated or managed. If you have been diagnosed with a chronic medical condition, UnitedHealthcare may contact you to discuss this program. Or you may call UnitedHealthcare at 1-800-842-5252 to learn whether you are eligible to participate in a program. Participation is voluntary, and there is no charge for these services.

Through disease management services, benefits for alternative treatment, which are otherwise not Covered Health Services, may be offered to you or your Dependent when it is appropriate and cost effective. The decision to accept alternative treatment rests with the patient and Physician.

Telephonic Access to Nurses and Counselors

UnitedHealthcare provides a toll-free telephone number that puts you in immedicate contact with a registered nurse any time, 24 hours a day, seven days a week. These nurses can provide health information for routine or urgent health concerns, such as a recent diagnosis, a minor sickness or injury, or other health-related topics. You can also listen to pre-recorded messages on a variety of medical topics.

This service is available to you and your Dependents at no charge. To use it, you can call UnitedHealthcare at 1-866-735-5685.

WELLNESS PROGRAMS

Healthy Weight Program

UnitedHealthcare provides a non-surgical approach to addressing weight and obesity through nutritional and activity guidance. You may receive free educational information on the web or through the mail and may even be called by a health coach who is a specialist in weight management. This health coach will be a resource to advise and help you manage your weight.

This program offers:

- on-line self-help tools: health assessment, exercise tracker, meal planner, calorie counter and educational content;
- education on weight management and self-care strategies;
- nutritional guidance and counseling by a health coach and registered dietician (if needed); and
- activity recommendations and encouragement by a health coach and exercise physiologist (if needed).

Participation is completely voluntary and without extra charge. If you would like to participate or would like additional information regarding the program, please call the number on the back of your ID card.

Tobacco Cessation Program

UnitedHealthcare provides a tobacco cessation program to help smokers withdraw from nicotine dependence. By participating in this program, you will receive educational material through the mail and one on one telephone sessions with trained cessation specialists.

This program offers:

- a quit smoking kit that includes a cessation manual and quit aids designed to provide support through this program;
- toll-free telephone access to cessation specialists (you will receive five (5) coaching sessions and may place unlimited calls to the cessation specialists when you have a question); and
- medication recommendations, and/or free over-the-counter nicotine replacement therapies if you or your Dependent is over the age of 18.

Participation is completely voluntary and without extra charge. If you would like to participate or would like additional information regarding the program, please call the number on the back of your ID Card.

Health Assessment

You and your spouse are invited to learn more about your health and wellness at **myuhc.com** and are encouraged to participate in the online health assessment. The health assessment is an interactive questionnaire designed to help you identify your healthy habits as well as potential health risks.

Your health assessment is kept confidential. Completing the assessment will not impact your benefits or eligibility for benefits in any way.

To find the health assessment, log in to **myuhc.com**. After logging in, access your personalized *Health & Wellness* page and click the *Health Assessment* link. If you need any assistance with the online assessment, please call the number on the back of your ID card.

[Next Steps

Individuals that complete a health assessment and are identified with three or more high risk factors, will be provided with telephonic outbound coaching. Coaching will be provided for any/all of the following topics, as appropriate; participation is completely voluntary and without extra charge:

- exercise,
- blood pressure management;
- smoking cessation;
- nutrition;
- stress management;
- cholesterol management; and
- back care/ergonomics.]

VI
PLAN C

APPLICABLE TO PERSONS NOT ELIGIBLE UNDER MEDICARE, GA-46000 THE AMTRAK EARLY RETIREMENT MEDICAL PLAN, THE KEOLIS COMMUTER SERVICES (FORMERLY MBCR) EARLY RETIREMENT PLAN, THE TRANSITAMERICA SERVICES, INC. (TASI) EARLY RETIREMENT PLAN

MAJOR MEDICAL EXPENSE BENEFITS

The Plan pays a percentage of Covered Expenses incurred in a calendar year which exceed the Deductible.

DEDUCTIBLE

The Deductible amount is [$500 - $3,000]. It applies separately to each covered individual each calendar year.

PERCENTAGE OF COVERED EXPENSES PAYABLE

The Plan pays [60% - 80%] (75% for the first 40 outpatient visits for alcoholism, chemical dependency and/or mental illness, and 60% for any visits thereafter) of the Covered Expenses in a calendar year after the Deductible is satisfied.

The Plan pays [40-60]% of the Covered Expenses in a calendar year after the Deductible is satisfied when Care Coordination is not called when required. See the Care Coordination description contained in this Section VI.

The Plan pays 100% of Covered Expenses in a calendar year after the Out-of-Pocket Maximum is met. ([70-90]% if Care Coordination is not called when required.)

OUT-OF-POCKET MAXIMUM

The Out-of-Pocket Maximum limits the amount of Covered Expenses you will have to pay for any one covered individual in a calendar year. The Out-of-Pocket Maximum is [$5,000 - $30,000] each calendar year. Covered Expenses used to satisfy your Deductible are also used to help satisfy your Out-of-Pocket Maximum.

The following expenses do not count in determining if any Out-of-Pocket Maximum has been met:

- Charges you pay that are in excess of the Reasonable Charge.
- Charges you pay that are in excess of specific Plan limits or exclusions.
- Charges you pay for expenses not covered by the Plan.
- [Charges you pay as a result of the reduction in benefits payable when Care Coordination is not notified or if the service or supply, although a Covered Health Service, is not Medically Appropriate.]

MAXIMUM AMOUNT

The Maximum Amount payable with respect to you or any of your Dependents is [$200,000 - unlimited]. The Maximum Amount applies to a person's entire lifetime and is a combined lifetime maximum under Plans A, B and C.

The Maximum Amount for anyone who has received benefits will be restored each January 1 by $1,000, or lesser amount, until the maximum is again [$200,000 - unlimited].

COVERED EXPENSES

Covered Expenses are the actual cost to you of the Reasonable Charges (see Definitions) for Covered Health Services (see Definitions) and supplies listed below. The service or supply must be needed because of injury, sickness or pregnancy.

A service or supply is not a Covered Health Service just because it is furnished by, or ordered by, your provider. The services and supplies will be reviewed by UnitedHealthcare to determine if they are considered Covered Health Services.

Acupuncture Services

Acupuncture services for the following conditions:

- Pain therapy, when another method of pain management has failed.
- Nausea that is related to surgery, pregnancy or chemotherapy.

Acupuncture services must be performed in an office setting by a provider who is one of the following, either practicing within the scope of his/her license (if state license is available) or who is certified by a national accrediting body:

- Doctor of Medicine
- Doctor of Osteopathy
- Acupuncturist
- Chiropractor
- Physician's Assistant

Allergy Immunotherapy Received in a Physician's Office

Benefits are available for allergy immunotherapy received in a Physician's office.

Ambulatory Surgical Center

Charges for services and supplies furnished in an Ambulatory Surgical Center in connection with a surgical procedure within 24 hours from and in connection with the surgical procedure.

Anesthetics

Applied Behavioral Analysis Services

Applied Behavioral Analysis (ABA) services for Autism Spectrum Disorders that are:

- Focused on the treatment of core deficits of Autism Spectrum Disorder;
- Provided by a *Board Certified Applied Behavioral Analyst (BCBA)* or other qualified provider under the appropriate supervision; and
- Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property, and impairment in daily functioning.
- Services include the following:
- Diagnostic evaluations, assessment and treatment planning.
- Treatment and/or procedures.
- Medication management and other associated treatments.
- Individual, family, and group therapy.
- Provider-based case management services.
- Crisis intervention.

[Assistant Surgeon

Coverage for assistant surgeon services are limited to 1/5 of the amount of the Reasonable Charge for the surgeon's charge for the surgery. An assistant surgeon must be a Physician. Surgical assistant's services are covered at the same or lesser rate.]

Chemotherapy

Clinical Trials

Routine patient care costs incurred during participation in an approved clinical trial meeting the approved clinical trial criteria stated below.

Benefits include the reasonable and necessary items and services used to diagnose and treat complications arising from participation in an approved clinical trial.

Benefits are available only when the Covered Family Member is clinically eligible for participation in the clinical trial as defined by the researcher. Benefits are not available for preventive clinical trials.

Routine patient care costs for clinical trials include:

- Covered Health Services for which benefits are typically provided absent a clinical trial.
- Covered Health Services required solely for the provision of the investigational item or service, the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications.
- Covered Health Services needed for reasonable and necessary care arising from the provision of an investigational item or service.

Routine costs for clinical trials do not include:

- The Experimental or Investigational Service or item. The only exceptions to this are:
  - Certain Category B devices.
  - Certain promising interventions for patients with terminal illnesses.
  - Other items and services that meet specified criteria in accordance with our medical policy guidelines.
- Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.
- Items and services provided by the research sponsors free of charge for any person enrolled in the trial.

To be an approved clinical trial, a clinical trial must meet all of the following criteria:

- Be approved and funded in full or in part by one or more of the following:
  - National Institutes of Health (NIH). (Includes National Cancer Institute (NCI).)
  - Centers for Disease Control and Prevention (CDC).
  - Agency for Healthcare Research and Quality (AHRQ).
  - Centers for Medicare and Medicaid Services (CMS).
  - A bona fide clinical trial cooperative group, including the National Cancer Institute Clinical Trials Cooperative Group, the National Cancer Institute Community Clinical Oncology Program, the AIDS Clinical Trials Group, and the Community Programs for Clinical Research in AIDS.
  - The Department of Defense (DOD), the Department of Veterans Affairs, or the Department of Energy, or a qualified nongovernmental research entity to which the National Cancer Institute has awarded a support grant.
  - A study or investigation approved by the Food and Drug Administration (FDA), including those conducted under an investigational new drug or device application reviewed by the FDA.
  - An investigation or study approved by an Institutional Review Board registered with the Department of Health and Human Services that is associated with an institution that has a federal-wide assurance approved by the Department of Health and Human Services specifying compliance with federal regulations.
- The clinical trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (IRBs) before participants are enrolled in the trial. We may, at any time, request documentation about the trial to confirm that the clinical trial meets current standards for scientific merit and has the relevant IRB approvals.

The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Service and is not otherwise excluded under the Policy.

Convenient Care Clinic

Diabetes Treatment

Coverage for diabetic equipment, diabetes supplies and in-person outpatient diabetic self-management training and education programs (including medical nutrition therapy) when provided under the direction of a Physician by a certified, registered or licensed health care professional.

Diabetes self-management training includes training provided to a Covered Person after the initial diagnosis in the care and management of that condition, including nutritional counseling and proper use of diabetes equipment and supplies. Coverage is also provided for additional training upon diagnosis of a significant change in medical condition that requires a change in the self-management regime, and a periodic continuing education training as warranted by the development of new techniques and treatment for diabetes.

Durable Medical Equipment

Durable Medical Equipment that meets each of the following criteria:

- Ordered or provided by a Physician for outpatient use primarily in a home setting.
- Used for medical purposes.
- Not consumable or disposable except as needed for the effective use of covered Durable Medical Equipment.
- Not of use to a person in the absence of a disease or disability.

Examples of Durable Medical Equipment include:

- Equipment to assist mobility, such as a standard wheelchair.
- A standard Hospital-type bed. Non-hospital beds, comfort beds, and motorized beds/mattresses are generally excluded from coverage.
- Oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks).
- Delivery pumps for tube feedings (including tubing and connectors).
- Braces, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are considered Durable Medical Equipment and are a Covered Health Service. Braces that straighten or change the shape of a body part are orthotic devices, and are excluded from coverage. Dental braces are also excluded from coverage.
- Mechanical equipment necessary for the treatment of chronic or acute respiratory failure (air-conditioners, humidifiers, dehumidifiers, air purifiers and filters, and personal comfort items are excluded from coverage).
- Burn garments.
- Insulin pumps and all related necessary supplies.
- Wigs, but only for loss of hair resulting from treatment of a malignancy or permanent loss of hair from an accidental injury, and up to a maximum of [$500 per calendar year].
- Speech aid prosthetics and traceo-esophaeal voice prosthetics. All other devices and computers to assist in communication and speech are not considered Durable Medical Equipment.
- External prosthetic devices that replace a limb or body part.

Benefits under this section do not include:

- Durable Medical Equipment provided to you by a Physician.
- Generally, any device, appliance, pump, machine stimulator, or monitor that is fully implanted into the body.

If you have any questions regarding whether a particular item is considered to be Durable Medical Equipment, please contact Care Coordination.

Care Coordination must be contacted for any purchase or rental of Durable Medical Equipment that exceeds [$1,000]. UnitedHealthcare will decide if the equipment should be purchased or rented.

Benefits that are available for repairs and replacement, except that:

- Benefits for repair and replacement do not apply to damage due to misuse, malicious breakage or gross neglect.
- Benefits are not available to replace lost or stolen items.
- Replacement of Durable Medical Equipment is limited to every three years, unless there are catastrophic circumstances, in which case you should notify UnitedHealthcare and an individual case evaluation will be performed.

If more than one piece of Durable Medical Equipment can meet your functional needs, benefits are available only for the equipment that meets the minimum specifications for your needs. If you rent or purchase a piece of Durable Medical Equipment that exceeds this guideline, you will be responsible for any cost difference between the piece you rent or purchase and the piece that UnitedHealthcare has determined is the most cost-effective.

Emergency Transportation Services

Transportation charges are covered for transportation to a Hospital in connection with an emergency.

The transportation services must be to a Hospital in your local area. If there are no local Hospitals that can provide the care needed, charges for transportation to the nearest Hospital outside your local area qualified to give the required treatment, will be covered.

Habilitative Services

Habilitative Services for children from birth to age 21 are covered, except for Habilitative Services provided in early intervention and school services.

Habilitative Services includes services, including occupational therapy, physical therapy, and speech therapy, for the treatment of a child with a congenital or genetic birth defect to enhance the child's ability to function. For purposes of Habilitaitive Services, a cogenital or genetic birth defect means a defect existing at or from birth, including a hereditary defect. A congential or genetic birth defect includes, but is not limited to (a) autism or autism spectrum disorder, and (b) cerebral palsy.

Home Health Care Agency Services

Charges for services of a Home Health Care Agency prescribed in writing by a Physician to be in lieu of Hospital confinement, up to a maximum of 30 visits during any one calendar year. Each visit by a member of a home health care team will be considered as one home health care visit. Four hours of home health care services will be considered as one home health care visit. If a visit exceeds four hours, each additional four hours, or part thereof, will count as one additional visit. Each visit by any other member of the home health care team will count as an additional visit.

The following services and supplies of a Home Health Care Agency are covered:

- Temporary or part-time nursing care by or supervised by a registered graduate nurse (R.N.).
- Temporary or part-time care by a home health aide.
- Physical therapy, occupational therapy or speech therapy.
- Medical supplies.
- Drugs and medications ordered by a Physician.
- X-ray and laboratory tests.

Hospice

Hospice care that is recommended by a Physician, for a period of up to six (6) months. Hospice care is an integrated program that provides comfort and support services for the terminally ill. Hospice care includes physical, psychological, social and spiritual care for the terminally ill person and short-term grief counseling for immediate family members while the patient is receiving hospice care.

You must notify and receive approval from Care Coordination prior to receiving any inpatient or outpatient hospice care in order to be eligible for this benefit.

Benefits are available when hospice care is received from a licensed hospice agency.

A Physician must certify that the patient is terminally ill and that the patient's life expectancy is six (6) months or less.

Hospital Services

Services and supplies provided by a Hospital on an inpatient basis, except that if charges are made for a private room, Covered Expenses will be limited to the hospital's average daily charge for a semi-private room.

Coverage is provided for up to 60 inpatient days per calendar year for alcoholism, chemical dependency and/or mental illness services. In addition, coverage is provided for up to 12 days per calendar year for inpatient detoxification services.

Coverage is also provided for newborn infant hearing screenings and all necessary audiological examinations provided as recommended by the national Joint Committee on Infant Hearing. For purposes of this coverage, "Hospital" shall include birthing centers or other centers having newborn nurseries.

Services and supplies provided by a Hospital on an outpatient basis including:

- Emergency care and treatment for a medical emergency, including the sudden onset or worsening of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent lay person, who possesses an average knowledge of health and medicine to result in:
  - Placing the patient's health in serious jeopardy;
  - Serious impairment to bodily functions; or
  - Serious dsyfunction of any bodily organ or part.
- Voluntary HIV screening test performed while receiving emergency care in a Hospital, once per calendar year, regardless of whether or not the HIV screening is necessary for the treatment of the condition for which the emergency care is sought..

Medical Supplies

- Medical and surgical supplies (such as bandages and dressings). Supplies given during surgery or a diagnostic procedure are included in the overall cost for that surgery or diagnostic procedure.
- Blood or blood derivatives only if not donated or replaced.

Multiple Surgical Procedures

When more than one surgical procedure is performed during the same operative session, Covered Expenses are limited as follows:

- Covered Expenses for the second procedure will be limited to 50% of the Reasonable Charge for that procedure had it been performed alone.
- Covered Expenses for any subsequent procedure are limited to 50% of the Reasonable Charge for the subsequent procedures.

Organ/Tissue Transplants

- Donor Charges

  In the case of an organ or tissue transplant, no services or supplies for the donor are considered Covered Health Services unless the recipient is the Employee or his/her Dependent. If the recipient is not the Employee or his/her Dependent, no benefits are payable for donor charges.

  The search for bone marrow/stem cell from a donor who is not biologically related to the patient is not considered a Covered Health Service UNLESS the search is made in connection with a transplant procedure arranged by a Transplant Facility.

- Qualified Procedures

  If a qualified procedure, listed below, is Medically Appropriate and performed at a Transplant Facility, the "Medical Care and Treatment" and "Transportation and Lodging" provisions set forth below apply:

    - Heart transplants
    - Heart/lung transplants
    - Liver transplants
    - Kidney transplants
    - Pancreas transplants
    - Kidney/pancreas transplants
    - Bone marrow/stem cell transplants
    - Other transplant procedures when UnitedHealthcare determines that it is necessary to perform the procedure at a Treatment Facility.

  If a transplant, even if determined to be Medically Appropriate, is not performed at a Transplant Facility, there will be no benefit payable for the "Medical Care and Treatment" or the "Transportation and Lodging" provisions set forth below.

- Medical Care and Treatment
  - The following services provided in connection with the transplant are Covered Health Services:
    - Pre-transplant evaluation for one of the procedures listed above
    - Organ acquisition and procurement
    - Hospital and Physician fees
    - Transplant procedures
    - Follow-up care for a period up to one year after the transplant
    - Search for bone marrow/stem cell from a donor who is not biologically related to the patient. If a separate charge is made for a bone marrow/stem cell search, a maximum benefit of $25,000 is payable for all charges made in connection with the search.

- Transportation and Lodging

  Care Coordination will assist the patient and family with travel and lodging arrangements. Expenses for travel, lodging and meals for the transplant recipient and a companion are available under this Plan as follows:

  - Reasonable and necessary expenses for transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of the transplant for the purposes of an evaluation, the transplant procedure or necessary post-discharge follow-up.
  - Reasonable and necessary expenses for lodging and meals for the patient (while not confined) and one companion. Benefits are paid at a per diem rate of up to $50 for one person or up to $100 for two people.

  Travel and lodging expenses are only available if the transplant recipient resides more than 50 miles from the Transplant Facility.

  If the Dependent who is the patient is a minor child, the transportation expenses of two companions will be covered and lodging and meal expenses will be reimbursed up to the $100 per diem rate.

  There is a combined overall lifetime maximum of $10,000 per Employee or Dependent for all transportation, lodging and meal expenses incurred by the transplant recipient and companion(s) and reimbursed under Plans A, B and C, combined, in connection with all transplant procedures.

Outpatient Alcoholism, Chemical Dependency and Mental Illness Services

Benefits for outpatient services to treat alcoholism, chemical dependency and/or mental illness. The Plan pays 75% of the Covered Expenses in a calendar year after the Deductible is satisfied for the first 40 outpatient visits for alcoholism, chemical dependency and/or mental illness, and then 60% of any additional visits.

Outpatient Rehabilitation

Short-term outpatient rehabilitation services, limited to:

- Physical therapy
- Occupational therapy
- Chiropractic treatment
- Speech therapy
- Pulmonary rehabilitation therapy
- Cardiac rehabilitation therapy

Rehabilitation services are limited to thirty (30) visits per calendar year for any combination of services.

Rehabilitation services must be performed by a Physician or by a licensed therapy provider. Benefits under this section include rehabilitation services provided in a Physician's office or on an outpatient basis at a Hospital.

We will pay benefits for speech therapy for the treatment of disorders of speech, language, voice, communication and auditory processing only when the disorder results from injury, stroke, cancer, congenital anomaly, or autism spectrum disorders.

Physician Services

Physician charges for professional services incurred:

- in a Physician's office;
- during a Hospital confinement;
- for the performance of a surgical operation; or
- in a Skilled Nursing Facility.

When determined to be a Covered Health Service, charges by an assistant surgeon are also covered under the plan.

Preventive Adult Health Services

- One routine physical examination per calendar year, subject to the calendar year Deductible.
- Necessary laboratory tests and/or immunizations, subject to the calendar year Deductible.
- Benefits are available for mammography testing that is consistent with the recommendations of governmental scientific agencies. Benefits for mammography testing are payable when mammography testing is performed as follows:
  - a baseline mammogram; and
  - follow-up mammograms on an annual basis.
- Pap smears are covered annually, or when it is determined by the attending physician that the test is necessary.

The preventive services listed above for mammograpy testing and pap smears are not subject to coinsurance or the calendar year Deductible.

- Colorectal cancer screenings are covered in compliance with the American Cancer Society colorectal cancer screenings guidelines.
- Prostate cancer screenings are covered in accordance with the latest screening guidelines used by the American Cancer Society.

Preventive Child Health Services

Benefits are available from birth to age 21 including:

- Coverage for injury or sickness, including the necessary care and treatment of medically diagnosed congenital defects, birth abnormalities, and prematurity; and

Coverage for preventive and primary care services, including physician examinations, measurements, sensory screening, neuropsychiatric evaluation, and development screening, which coverage shall include unlimited visits up to the age of 12 years, and 3 visits per year for minor children ages 12 years up to age 21 years of age. Preventive and primary care services shall also include, as recommended by the physician, hereditary and metabolic screening at birth, immunizations, urinalysis, tuberculin tests, and hematocrit, hemoglobin, and other appropriate blood tests, including tests to screen for sickle hemoglobinopathy.

Radiation Therapy

Skilled Nursing Facility

Services and supplies up to [20-60] days of confinement following each Hospital confinement per calendar year.

If charges are made for a private room, Covered Expenses will be limited to the facility's daily charge for a semi-private room.

Skilled nursing facility stays must be approved in advance by Care Coordination in order to be eligible for benefits.

Telehealth

Charges for services provided through telehealth rather than face-to-face consultation when the services can appropriately be provided through telehealth.

- "Telehealth" means the use of live, interactive audio and visual transmissions of a physician-patient encounter from one site to another using telecommunications technologies. They may include transmissions of real-time telecommunications or those transmitted by store-and-forward technology.

- Telemedicine services are medical services provided via interactive audio, video or other electronic media for the purpose of diagnosis, consultation, or treatmentthat do not involve direct, in-person patient contact.

Treatment Center Services

Charges for services at a Treatment Center, when a Physician or Psychologist has certified an alcoholism or chemical dependency and has prescribed such services, up to a calendar year maximum of 60 days. In addition, detoxification services will be covered for up to 12 days annually.

Urgent Care Center Services

Charges for Covered Health Services received at an Urgent Care Center.

X-ray and Laboratory Tests

IMPORTANT: It should be noted that the Covered Expenses listed above do not include charges for drugs, private duty nursing, Physician's home visits, and some other services and supplies which are covered under the Railroad Employees National Health and Welfare Plan, NRC/UTU Plan, GA-46000, the Amtrak Early Retirement Plan, the Keolis Commuter Services (formerly MBCR) Early Retirement Plan, the TransitAmerica Services, Inc. (TASI) Early Retirement Plan or GA-107300.

PREFERRED PROVIDERS

UnitedHealthcare has arranged with certain health care providers to become Preferred Providers. These Preferred Providers have agreed to discount their charges for Covered Expenses.

If Preferred Providers are used, the amount of Covered Expenses for which you are responsible will generally be less than the amount owed if other providers had been used. The percentage of Covered Expenses payable remains the same whether or not Preferred Providers are used. However, because the Covered Expenses may be less when Preferred Providers are used, the portion that you owe will be less.

You will receive an Identification Card showing that you and/or your Dependents Covered under Plans A, B or C, are entitled to these discounts. This Identification Card must be shown every time health care services are given. This is how the provider knows that you and/or your Dependent is covered under a Preferred Provider plan. Otherwise, you could be billed for the provider's normal charge.

Call UnitedHealthcare at 1-800-842-5252 to inquire about or locate Preferred Providers in your area. You may also access Preferred Provider information online at myuhc.com.

Preferred Providers are responsible for filing your claims directly to UnitedHealthcare. You do not need to submit claims for Preferred Providers services or supplies.

You must submit claims for services and supplies rendered by other providers as described in the section entitled Claim Information.

If a Preferred Provider bills you for any part of the discount amount, call UnitedHealthcare at 1-800-842-5252 for assistance.

CARE COORDINATION

Care Coordination is designed to encourage an efficient system of care for you and your Dependents by identifying possible unmet covered health needs. This may include admission counseling, inpatient care advocacy, and certain discharge planning and disease management activities. Care Coordination activities are not a substitute for the medical judgment of your Physician, however, and the ultimate decision as to what medical care you actually receive must be made by you and your Physician.

Care Coordination is triggered when UnitedHealthcare receives notification of an upcoming treatment or service. The notification process serves as a gateway to care coordination activities.

When to Notify Care Coordination

Care Coordination must be notified as soon as possible after you know that you require any of the services or supplies shown below:

- Inpatient admissions to a Hosptial or Skilled Nursing Facility
- Home health care
- Hospice care
- Durable medical equipment (over $1,000)
- Reconstructive procedures
- Dental services rendered as a result of an accident
- [Gender transformation surgery]

With regard to organ/tissue transplants, Care Coordination must be notified at least seven working days before the scheduled date of any of the following or as soon as reasonably possible:

- The evaluation of a transplant
- The donor search
- The organ procurement/tissue harvest
- The transplant procedure

For an in-patient confinement which is the result of an emergency, you (or your representative or Physician) must call Care Coordination within one day (excluding weekends and holidays) from the date the confinement begins.

You should notify Care Coordination promptly after you become aware that you are pregnant. You are required to give this notice, however, only if and when inpatient care for the mother or child is expected to continue beyond:

- 48 hours following a normal delivery; or
- 96 hours following a Caesarean section.

The notice you give must be given in sufficient time to allow UnitedHealthcare to complete a review of the matter before the services are rendered. In the absence of advance notice, UnitedHealthcare may not be able to complete its review and determine, before you incur expenses, if the service is a Covered Health Service, and if so, whether it is Medically Appropriate.

Remember: This notice obligation is your responsibility. It is not the responsibility of your Physician, your Hospital or any other provider.

How to Give the Required Notice

Notice should be given by telephone at 1-800-842-5252. You can call at any time, day or night. However, if you call outside of the normal hours of operation, you may leave a message with your telephone number on an answering machine, and your call will be returned within one working day.

What Happens After You Give the Required Notice?

UnitedHealthcare will review the services for which you have given notice and will determine whether they are Covered Health Services, and, if so, whether they are Medically Appropriate.

The ultimate decision on your medical care must be made by you and your Physician. Review by Care Coordination only determines whether the service or supply is a Covered Health Service, and if so, whether it is Medically Appropriate, solely for purposes of deciding what, if any, amounts are payable with respect to the service or supply under the Plan.

Effects on Benefits

- Benefits are reduced if you do not give the required notice or if UnitedHealthcare determines that the service or supply, although a Covered Health Services, is not Medically Appropriate. In either case, the benefit will be reduced from [60-80]% to [50-70]% of the benefits payable under the Plan. If you have satisfied your Out-of-Pocket Maximum, benefits will be reduced from 100% to [70-90]%.

- No benefits are payable if UnitedHealthcare determines that the service or supply is not a Covered Health Service.

If UnitedHealthcare determines that a service is not a Covered Health Service or is not Medically Appropriate, you or your Physician can appeal that determination. Please see the Claim Information section for a description of the appeal process.

Case Management Services

UnitedHealthcare also provides case management services. These services focus on severe illnesses and injuries which could result in long-term hospital confinements. UnitedHealthcare will determine whether case management services are appropriate in your case.

Through case management services, benefits for alternative treatment, which are otherwise not Covered Health Services, may be offered to you or your Dependent when it is appropriate and cost effective. The decision to accept alternative treatment rests with the patient and Physician.

Disease Management Services

UnitedHealthcare also provides disease management services. These programs focus on providing information about certain chronic medical conditions, such as heart failure, coronary artery disease, diabetes, or asthma, and the ways these conditions can be treated or managed. If you have been diagnosed with a chronic medical condition, UnitedHealthcare may contact you to discuss this program. Or you may call UnitedHealthcare at 1-800-842-5252 to learn whether you are eligible to participate in a program. Participation is voluntary, and there is no charge for these services.

Through disease management services, benefits for alternative treatment, which are otherwise not Covered Health Services, may be offered to you or your Dependent when it is appropriate and cost effective. The decision to accept alternative treatment rests with the patient and Physician.

Telephonic Access to Nurses and Counselors

UnitedHealthcare provides a toll-free telephone number that puts you in immedicate contact with a registered nurse any time, 24 hours a day, seven days a week. These nurses can provide health information for routine or urgent health concerns, such as a recent diagnosis, a minor sickness or injury, or other health-related topics. You can also listen to pre-recorded messages on a variety of medical topics.

This service is available to you and your Dependents at no charge. To use it, you can call UnitedHealthcare at 1-866-735-5685.

WELLNESS PROGRAMS

Healthy Weight Program

UnitedHealthcare provides a non-surgical approach to addressing weight and obesity through nutritional and activity guidance. You may receive free educational information on the web or through the mail and may even be called by a health coach who is a specialist in weight management. This health coach will be a resource to advise and help you manage your weight.

This program offers:

- on-line self-help tools: health assessment, exercise tracker, meal planner, calorie counter and educational content;
- education on weight management and self-care strategies;
- nutritional guidance and counseling by a health coach and registered dietician (if needed); and
- activity recommendations and encouragement by a health coach and exercise physiologist (if needed).

Participation is completely voluntary and without extra charge. If you think you would like to participate or would like additional information regarding the program, please call the number on the back of your ID card.

Tobacco Cessation Program

UnitedHealthcare provides a tobacco cessation program to help smokers withdraw from nicotine dependence. By participating in this program, you will receive educational material through the mail and one on one telephone sessions with trained cessation specialists.

This program offers:

- a quit smoking kit that includes a cessation manual and quit aids designed to provide support through this program;
- toll-free telephone access to cessation specialists (you will receive five (5) coaching sessions and may place unlimited calls to the cessation specialists when you have a question); and
- medication recommendations, and/or free over-the-counter nicotine replacement therapies if you or your Dependent are over the age of 18.

Participation is completely voluntary and without extra charge. If you think you would like to participate or would like additional information regarding the program, please call the number on the back of your ID Card.

Health Assessment

You and your spouse are invited to learn more about your health and wellness at **myuhc.com** and are encouraged to participate in the online health assessment. The health assessment is an interactive questionnaire designed to help you identify your healthy habits as well as potential health risks.

Your health assessment is kept confidential. Completing the assessment will not impact your benefits or eligibility for benefits in any way.

To find the health assessment, log in to **myuhc.com**. After logging in, access your personalized *Health & Wellness* page and click the *Health Assessment* link. If you need any assistance with the online assessment, please call the number on the back of your ID card.

[Next Steps

Individuals that complete a health assessment and are identified with three or more high risk factors, will be provided with telephonic outbound coaching. Coaching will be provided for any/all of the following topics, as appropriate; participation is completely voluntary and without extra charge:

- exercise,
- blood pressure management;
- smoking cessation;
- nutrition;
- stress management;
- cholesterol management; and
- back care/ergonomics.]

VI
PLAN E

APPLICABLE TO PERSONS ELIGIBLE UNDER THE RAILROAD EMPLOYEES NATIONAL EARLY RETIREMENT MAJOR MEDICAL BENEFIT PLAN (GA-46000)

This Plan has been developed to supplement the benefits for retired and disabled railroad Employees and their Dependents who qualify for coverage under GA-46000. Coverage under GA-46000 is provided by the participating railroads at no cost to eligible Employees.

In general, eligibility for coverage on the basis of age under GA-46000 is limited to Employees who apply to a "60/30" annuity under the Railroad Retirement Act of 1974 subject to the following requirements:

- Application for the "60/30" annuity is made on or after the date the Employee attains age 60.
- The Employee was covered under the Railroad Employees National Health and Welfare Plan or the NRC/UTU Plan on the day before the application for the "60/30" annuity is made.

However, Employees may apply for an annuity during the three months before their 60th birthday if they continue working or receive vacation pay into the month prior to the month in which their 60th birthday occurs. Employees will not be disqualified from participation in this Plan, provided they satisfy the other eligibility requirements.

In addition, GA-46000 covers certain disabled Employees who were still covered under the Railroad Employees National Health and Welfare Plan or the NRC/UTU Plan when they reached age 60. The disability qualification requirements are quite specific and any questions in this regard should be directed to your Employer, your Labor Organization or UnitedHealthcare, Railroad Administration, 450 Columbus Boulevard, P.O. Box 150476, Hartford, CT 06115-0476. A booklet containing a complete description of the rules governing eligibility for GA-46000 benefits is available through employing railroads.

If you qualify for coverage under GA-46000 you may enroll for Employee and/or Dependent benefits under Plan E provided your enrollment and payment are mailed (postmarked) to UnitedHealthcare on or before the last day of the month in which coverage under the Railroad Employees National Health and Welfare Plan or NRC/UTU Plan terminates or in the next three calendar months. If your benefits under an early retirement medical plan are paid by a hospital association, you may enroll for Dependent benefits only.

Your Employee coverage under GA-46000 ceases when you become eligible for Medicare due to age or disability. If you become eligible for Medicare due to end stage renal disease, your coverage under GA-46000 ends, after you have been eligible for Medicare for 30 months. If you qualify for Medicare due to age (65), your coverage under Plan E will be automatically transferred to Plan F. If you qualify for Medicare for reasons other than age, you must notify UnitedHealthcare so that coverage can be transferred from Plan E to Plan F.

Keep in mind that your Dependent coverage under GA-46000 terminates when you qualify for Medicare due to age (65). In the event of your death, your Dependent(s) will be covered until you would have qualified for Medicare due to age (65). When your Dependent(s) are no longer covered under GA-46000, coverage for Dependent(s) will automatically be transferred from Plan E to Plan C. If you would prefer to enroll your Dependent(s) in either Plan A or Plan B, of if you want to decline coverage for your Dependent(s), you will have to call UnitedHealthcare at 1-800-842-5252.

Your Dependents may be entitled to continue coverage under GA-46000 after it would otherwise terminate as a result of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Full information concerning COBRA has been made available to persons covered under GA-46000. If your

Dependents are continuing GA-46000 coverage under COBRA, your Dependents benefits will remain under Plan E. When their COBRA continuation coverage terminates, their GA-23111 coverage will automatically be transferred to Plan F if they are entitled to Medicare, or Plan C if they are not entitled to Medicare. If your Dependents are not entitled to Medicare, and you would prefer them to be enrolled in either Plan A or Plan B, or if you want to decline coverage for your Dependents, you will have to call UnitedHealthcare at 1-800-842-5252.

Coverage under GA-46000 for an individual Dependent will cease when that Dependent becomes eligible for Medicare. When this occurs, you must notify UnitedHealthcare so that coverage can be transferred from Plan E to Plan F.

MAJOR MEDICAL EXPENSE BENEFITS

The Plan pays [60% - 80%] (75% for the first 40 outpatient visits for alcoholism, chemical dependency and/or mental illness and 60% for any visits thereafter) of the Covered Expenses incurred in a calendar year which exceed the Deductible.

DEDUCTIBLE

The Deductible is separate for you and each of your Dependents each calendar year. It has two parts - a Basic Benefits Deductible and a Cash Deductible.

Basic Benefits Deductible

The Basic Benefits Deductible is the total payments made during the calendar year under GA-46000 or, if the benefits under GA-46000 are reduced in accordance with its Coordination of Benefits provisions, the payments which would have been made had such reduction not occurred.

Cash Deductible

The Cash Deductible is $[100 – 500].

PERCENTAGE OF COVERED EXPENSES PAYABLE

The Plan pays [60–80]% (75% for the first 40 outpatient visits for alcoholism, chemical dependency and/or mental illness and 60% for any visits thereafter) of Covered Expenses in a calendar year after the Deductible is satisfied.

The Plan pays 100% of the Covered Expenses in a calendar year after the Out-of-Pocket Maximum is met.

OUT-OF-POCKET MAXIMUM

The Out-of-Pocket Maximum limits the amount of Covered Expenses you will have to pay for any one covered individual in a calendar year. The Out-of-Pocket Maximum each calendar year is $[5,000 – 15,000]. Covered Expenses used to satisfy your Deductible are also used to help satisfy your Out-of-Pocket Maximum.

The following expenses do not count in determining if any Out-of-Pocket Maximum has been met:

- Charges you pay that are in excess of the Reasonable Charge.
- Charges you pay that are in excess of specific Plan limitations or exclusions.
- Charges you pay for expenses not covered by the Plan.
- Charges you pay as a result of a reduction in benefits under GA-46000 if the required Care Coordination notification is not made, or if Care Coordination determines that the service or supply is not a Covered Health Service as that term is defined under GA-46000.
- Co-payments you make and any other charges you pay under the GA-46000 Managed Pharmacy Services Benefit.

MAXIMUM AMOUNT

The Maximum Amount payable with respect to you or any one of your Dependents is $[300,000 – 1,000,000]. This Maximum Amount applies to a person's entire lifetime.

COVERED EXPENSES

Covered Expenses are the actual cost to you of the Reasonable Charges (see Definitions) for the Covered Health Services (see Definitions) listed below. The service or supply must be needed because of injury, sickness or pregnancy.

A service or supply is not a Covered Health Service just because it is furnished by, or ordered by, your provider. The services and supplies will be reviewed by UnitedHealthcare to determine if they are covered under the Plan.

The services and supplies for which Covered Expenses may be incurred are as follows:

Ambulatory Surgical Center Services

Services given within 72 hours before or after a surgical procedure. The services have to be given in connection with the procedure.

Anesthetics

Applied Behavioral Analysis Services

Applied Behavioral Analysis (ABA) services for Autism Spectrum Disorders that are:

- Focused on the treatment of core deficits of Autism Spectrum Disorder;
- Provided by a *Board Certified Applied Behavioral Analyst (BCBA)* or other qualified provider under the appropriate supervision; and
- Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property, and impairment in daily functioning.
- Services include the following:
- Diagnostic evaluations, assessment and treatment planning.
- Treatment and/or procedures.
- Medication management and other associated treatments.
- Individual, family, and group therapy.
- Provider-based case management services.
- Crisis intervention.

Birth Center Services

Chemotherapy

Clinical Trials

Routine patient care costs incurred during participation in an approved clinical trial meeting the approved clinical trial criteria stated below.

Benefits include the reasonable and necessary items and services used to diagnose and treat complications arising from participation in an approved clinical trial.

Benefits are available only when the Covered Family Member is clinically eligible for participation in the clinical trial as defined by the researcher. Benefits are not available for preventive clinical trials.

Routine patient care costs for clinical trials include:

- Covered Health Services for which benefits are typically provided absent a clinical trial.
- Covered Health Services required solely for the provision of the investigational item or service, the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications.
- Covered Health Services needed for reasonable and necessary care arising from the provision of an investigational item or service.

Routine costs for clinical trials do not include:

- The Experimental or Investigational Service or item. The only exceptions to this are:
  - Certain Category B devices.
  - Certain promising interventions for patients with terminal illnesses.
  - Other items and services that meet specified criteria in accordance with our medical policy guidelines.
- Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.
- Items and services provided by the research sponsors free of charge for any person enrolled in the trial.

To be an approved clinical trial, a clinical trial must meet all of the following criteria:

- Be approved and funded in full or in part by one or more of the following:
  - National Institutes of Health (NIH). (Includes National Cancer Institute (NCI).)
  - Centers for Disease Control and Prevention (CDC).
  - Agency for Healthcare Research and Quality (AHRQ).
  - Centers for Medicare and Medicaid Services (CMS).
  - A bona fide clinical trial cooperative group, including the National Cancer Institute Clinical Trials Cooperative Group, the National Cancer Institute Community Clinical Oncology Program, the AIDS Clinical Trials Group, and the Community Programs for Clinical Research in AIDS.
  - The Department of Defense (DOD), the Department of Veterans Affairs, or the Department of Energy, or a qualified nongovernmental research entity to which the National Cancer Institute has awarded a support grant.
  - A study or investigation approved by the Food and Drug Administration (FDA), including those conducted under an investigational new drug or device application reviewed by the FDA.
  - An investigation or study approved by an Institutional Review Board registered with the Department of Health and Human Services that is associated with an institution that has a federal-wide assurance approved by the Department of Health and Human Services specifying compliance with federal regulations.
- The clinical trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (IRBs) before participants are enrolled in the trial. We may, at any time, request documentation about the trial to confirm that the clinical trial meets current standards for scientific merit and has the relevant IRB approvals.

The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Service and is not otherwise excluded under the Policy.

Diabetes Treatment

Coverage for diabetic equipment, diabetes supplies and in-person outpatient diabetic self-management training and education programs (including medical nutrition therapy) when provided under the direction of a Physician by a certified, registered or licensed health care professional.

Diabetes self-management training includes training provided to a Covered Person after the initial diagnosis in the care and management of that condition, including nutritional counseling and proper use of diabetes equipment and supplies. Coverage is also provided for additional training upon diagnosis of a significant change in medical condition that requires a change in the self-management regime, and a periodic continuing education training as warranted by the development of new techniques and treatment for diabetes.

Durable Medical Equipment

Durable Medical Equipment means equipment that meets all of the following criteria:

- It is for repeated use and is not consumable or disposable
- It is used primarily for a medical purpose
- It is appropriate for use in the home

Some examples of durable medical equipment are:

- Appliances that replace a lost body organ or part or help an impaired one to work
- Orthotic devices such as arm, leg, neck and back braces
- Hospital-type beds
- Equipment needed to increase mobility, such as a wheelchair
- Respirators or other equipment for the use of oxygen
- Monitoring devies

Care Coordination must be contacted for any purchase or rental costs which exceed [$1,000]. Care Coordination will determine whether the purchase or rental of the equipment is Medically Appropriate.

Habilitative Services

Habilitative Services for children from birth to age 21 are covered, except for Habilitative Services provided in early intervention and school services.

Habilitative Services includes services, including occupational therapy, physical therapy, and speech therapy, for the treatment of a child with a congenital or genetic birth defect to enhance the child's ability to function. For purposes of Habilitaitive Services, a cogenital or genetic birth defect means a defect existing at or from birth, including a hereditary defect. A congential or genetic birth defect includes, but is not limited to (a) autism or autism spectrum disorder, and (b) cerebral palsy.

Home Health Care Agency Services

- Part-time or intermittent nursing care rendered by or supervised by a registered nurse.
- Part-time or intermittent care by a home health aide.
- Physical therapy or occupational therapy.
- Speech therapy to restore speech lost or impaired due to removal of vocal cords, cerebral thrombosis, or brain damage due to injury or organic brain lesion.
- Prescription Drugs.
- Medical Supplies.
- X-rays and laboratory tests.

Hospice Care Services

Up to a maximum payment of [$3,000] for each Course of Care for room, board, care and treatment charged by a Hospice.

Up to a maximum payment of [$1,000] for each Course of Care for:

- Counseling for the patient's Immediate Family. Services must be given by a licensed social worker or a licensed pastoral counselor.
- Bereavement counseling up to [15] visits for the patient's Immediate Family. Services must be given by a licensed social worker or a licensed pastoral counselor and given within six months after the patient's death.

The Physician must certify that the patient is terminally ill with 6 months or less to live.

"Immediate Family" means you or any member of your family who is covered under this Plan.

"Course of Care" means all services given to the patient and the patient's Immediate Family in connection with the terminal illness of the patient.

Services provided by a licensed pastoral counselor to a member of his/her congregation in the course of his/her normal duties as a pastor or minister will not be considered a Covered Expense.

Hospital Services

Services and supplies provided by a Hospital on an inpatient or outpatient basis.

If charges are made for a private room, Covered Expenses will be limited to the hospital's average daily charge for a semi-private room.

Coverage is also provided for up to 60 inpatient days per calendar year for alcoholism, chemical dependency and/or mental illness services. In addition, coverage is provided for up to 12 days per calendar year for inpatient detoxification services.

Coverage is also provided for newborn infant hearing screenings and all necessary audiological examinations provided as recommended by the National Joint Committee on Infant Hearing. For purposes of this coverage, "Hospital" shall include birthing centers or other centers having newborn nurseries.

Services and supplies provided by a Hospital for emergency care and treatment for a medical emergency, including the sudden onset or worsening of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent lay person, who possesses an average knowledge of health and medicine to result in:

- Placing the patient's health in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dsyfunction of any bodily organ or part.

Coverage is also provided for the cost of a voluntary HIV screening test performed while receiving emergency care in a Hospital, once per calendar year, regardless of whether or not the HIV screening is necessary for the treatment of the condition for which the emergency care is sought.

Infertility Treatment

Diagnosis and treatment of infertility, including surgery and drug therapy. This does not include procedures or services to facilitate a pregnancy, such as, but not limited to, in vitro fertilization, embryo transfer, artificial insemination and immunotherapy for infertility.

Medical Supplies

- Surgical supplies (such as bandages and dressings). Supplies given during surgery or a diagnostic procedure are included in the overall cost for that surgery or diagnostic procedure.
- Blood or blood plasma only if not donated or replaced.

Nursing Services

Services of a trained nurse or a Nurse-Midwife.

Occupational Therapy

Servies of a licensed occupational therapist provivded the following conditions are met:

- The therapy must be ordered and monitored by a Physician.
- The therapy must be given in accordance with a written treatment plan approved by a Physician. The therapist must submit progress reports to the Physician at the intervals stated in the treatment plan.
- The therapy must be expected to result in significant, objective, measurable physical improvement within 2 months of the start of treatment.

Organ/Tissue Transplants

- Donor Charges

  In the case of an organ or tissue transplant, no services or supplies for the donor are considered Covered Health Services unless the recipient is the Employee or his/her Dependent. If the recipient is not the Employee or his/her Dependent, no benefits are payable for donor charges.

  The search for bone marrow/stem cell from a donor who is not biologically related to the patient is not considered a Covered Health Service UNLESS the search is made in connection with a transplant procedure arranged by a Transplant Facility.

- Qualified Procedures

  If a qualified procedure, listed below, is Medically Appropriate, the "Medical Care and Treatment" provisions set forth below apply:

  - Heart transplants
  - Heart/lung transplants
  - Liver transplants
  - Kidney transplants
  - Pancreas transplants
  - Kidney/pancreas transplants
  - Bone marrow/stem cell transplants
  - Other transplant procedures when UnitedHealthcare determines that it is necessary to perform the procedure at a Treatment Facility.

- Medical Care and Treatment
  - The following services provided in connection with the transplant are Covered Health Services:
    - Pre-transplant evaluation for one of the procedures listed above
    - Organ acquisition and procurement
    - Hospital and Physician fees
    - Transplant procedures
    - Follow-up care for a period up to one year after the transplant
    - Search for bone marrow/stem cell from a donor who is not biologically related to the patient. If a separate charge is made for a bone marrow/stem cell search, a maximum benefit of $25,000 is payable for all charges made in connection with the search.

- Transportation and Lodging

  The following benefits for transportation and lodging expenses are available for those Medically Appropriate Qualified Procedures, as listed above, that are performed at a Transplant Facility. If a Transplant Facility is not used, then these transportation and lodging benefits will not be covered.

  Care Coordination will assist the patient and family with travel and lodging arrangements. Expenses for travel, lodging and meals for the transplant recipient and a companion are available under this Plan as follows:

  - Reasonable and necessary expenses for transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of the transplant for the purposes of an evaluation, the transplant procedure or necessary post-discharge follow-up.
  - Reasonable and necessary expenses for lodging and meals for the patient (while not confined) and one companion. Benefits are paid at a per diem rate of up to $50 for one person or up to $100 for two people.

  Travel and lodging expenses are only available if the transplant recipient resides more than 50 miles from the Transplant Facility.

  If the Dependent who is the patient is a minor child, the transportation expenses of two companions will be covered and lodging and meal expenses will be reimbursed up to the $100 per diem rate.

There is a combined overall lifetime maximum of $10,000 per Employee or Dependent for all transportation, lodging and meal expenses incurred by the transplant recipient and companion(s) and reimbursed under this Plan E [and Plans A, B and/or C, combined], in connection with all transplant procedures.

Outpatient Alcoholism, Chemical Dependency and Mental Illness Services

Benefits for outpatient services to treat alcoholism, chemical dependency and/or mental illness. The Plan pays 75% of the Covered Expenses in a calendar year after the Deductible is satisfied for the first 40 outpatient visits for alcoholism, chemical dependency and/or mental illness, and then 60% of any additional visits.

Physical Therapy

Services of a licensed physical therapist, provided the following conditions are met:

- The therapy must be ordered and monitored by a Physician.
- The therapy must be given in accordance with a written treatment plan approved by a Physician.
- The therapist must submit progress reports to the Physician at the intervals stated in the treatment plan.

The therapy must be expected to result in significant, objective, measurable physical improvement within two months of the start of the treatment.

Physicians Services

Prescription Drugs

Prescription drugs other than those obtained from a retail pharmacy or by mail order.

Prescription Contraceptive Devices

Devices approved by the U.S. Food and Drug Administration for the prevention of a pregnancy are covered for female employees and the wives of male employees.

Preventive Adult Health Services

- Benefits are available for mammography testing that is consistent with the recommendations of governmental scientific agencies. Benefits for mammography testing are payable when mammography testing is performed as follows:
  - a baseline mammogram; and
  - follow-up mammograms on an annual basis.
- Pap smears are covered annually, or when it is determined by the attending physician that the test is necessary.

The preventive services listed above are not subject to coinsurance or the calendar year Deductible.

- Colorectal cancer screenings are covered in compliance with the American Cancer Society colorectal cancer screenings guidelines.
- Screenings in accordance with the latest screening guidelines issued by the American Cancer Society.

Preventive Child Health Services

Benefits are available from birth to age 21 including:

- Coverage for injury or sickness, including the necessary care and treatment of medically diagnosed congenital defects, birth abnormalities, and prematurity; and
- Coverage for preventive and primary care services, including physician examinations, measurements, sensory screening, neuropsychiatric evaluation, and development screening, which coverage shall include unlimited visits up to the age of 12 years, and 3 visits per year for minor children ages 12 years up to age 21 years of age. Preventive and primary care services shall also include, as recommended by the physician, hereditary and metabolic screening at birth, immunizations, urinalysis, tuberculin tests, and hematocrit, hemoglobin, and other appropriate blood tests, including tests to screen for sickle hemoglobinopathy.

Psychologist Services

Radiation Therapy

Rehabilitative Services

Benefits for occupational therapy, speech therapy and physical therapy for Dependent children, under the age of 21, with congenital or birth defects (including autism and cerebral palsy).

Skilled Nursing Facility Care After Hospital Confinement

Services and supplies up to 31 days of confinement following each Hospital confinement.

Separate confinements for the same cause are considered to be one confinement, unless separated by 14 or more days.

If charges are made for a private room, Covered Expenses will be limited to the facility's daily charge for a semi-private room.

Speech Therapy

These services must be given to restore speech. The speech must have been lost or impaired due to one of the following:

- Removal of vocal cords.
- Cerebral thrombosis (cerebral vascular accident).
- Brain damage due to injury or organic brain lesion (aphasia).

The therapy must be expected to result in significant, objective, measurable physical improvement within two months of the start of the treatment.

Spinal Manipulations

Services of a physician given for the detection or correction (manipulation) by manual or mechanical means of structural imbalance or distortion in the spine.

No benefits are available for any type of therapy, service or supply, including, but not limited to, spinal manipulation by a chiropractor or other phsycian once the therapy, service or supply ceases to be therapeutic and is instead administered to maintain a level of functioning or to prevent a medical problem from occuring or reoccurring.

Telehealth

Charges for services provided through telehealth rather than face-to-face consultation when the services can appropriately be provided through telehealth.

- "Telehealth" means the use of live, interactive audio and visual transmissions of a physician-patient encounter from one site to another using telecommunications technologies. They may include transmissions of real-time telecommunications or those transmitted by store-and-forward technology.

- Telemedicine services are medical services provided via interactive audio, video or other electronic media for the purpose of diagnosis, consultation, or treatment that do not involve direct, in-person patient contact.

Transportation Services

Transportation charges are covered for transportation to a Hospital in an emergency.

The transportation services must be to a Hospital in your local area. If there are no local Hospitals that can provide the care needed, charges for transportation to the nearest Hospital outside your local area qualified to give the required treatment, will be covered.

Treatment Center Services

Charges for services at a Treatment Center when a Physician or Psychologist has certified an alcoholism or chemical dependency and has prescribed such services, up to a calendar year maximum of 60 days. In addition, detoxification services will be covered for up to 12 days annually.

X-ray and Laboratory Tests

EXCLUSIONS

Major Medical Expenses Benefits are not payable for expenses for:

- Expenses for any confinement, treatment, services or supplies which would have been payable under GA-46000, but which were not payable due to you or your Dependent's non-compliance with Care Coordination described under GA-46000.
- Prescription Drugs purchased from a pharmacy or by mail order.
- Expenses for treatment of on-duty injuries if the railroad has paid those expenses.

Other exclusions that apply to this Benefit are in the General Exclusions section.

VII
PLAN F

APPLICABLE TO PERSONS ELIGIBLE FOR FULL MEDICARE COVERAGE

This plan is available to Persons Eligible Under Medicare who are not eligible under the Railroad Employees National Health and Welfare Plan, the [NRC/UTU Plan], GA-46000, GA-107300, the Amtrak Early Retirement Plan, the Keolis Commuter Services (formerly MBCR) Early Retirement Plan, or the TransitAmerica Services, Inc. (TASI) Early Retirement Plan.

INFORMATION ABOUT MEDICARE

An individual becomes eligible under Medicare:

- On the basis of **age,** on the first day of the month in which he or she attains age 65 (if an individual's birthday is on the first day of the month, he is considered to reach 65 in the previous month).
- On the basis of **disability,** on the first day of the month following receipt of disability benefits for 24 consecutive months under Railroad Retirement or Social Security. There is a waiting period of 5 full calendar months of disability before disability benefits begin. To be eligible for Medicare, a Railroad Retirement beneficiary must meet the disability qualifications of the Social Security Act which require that an individual be totally disabled (unable to perform the duties of any occupation).
- On the basis of **end stage renal disease,** on the first day of the third month after the month in which a course of renal dialysis is initiated, or when a kidney transplant is received.

Individuals who are receiving age or disability benefits under Social Security or Railroad Retirement will be automatically enrolled under Medicare. No payment is required under Part A of Medicare. The required payment under Part B of Medicare will be deducted automatically from the individual's monthly benefit. An individual may file a waiver form with Social Security or Railroad Retirement declining Part B coverage. If the individual does so, no deduction will be made from the monthly benefit but the individual will not have the maximum available coverage.

Individuals age 65 or over who are not otherwise eligible for coverage under Part A of Medicare may voluntarily enroll for such coverage. These individuals must pay the full cost of such coverage and must also enroll for coverage under Part B of Medicare.

An individual with end stage renal disease will have to enroll under Medicare in order to have coverage for Medicare benefits. Information about such enrollment should be obtained from a Railroad Retirement Board or Social Security Administration office.

INFORMATION ABOUT PLAN F

Plan F is not a replacement for Medicare. Any individual eligible for Medicare who declines Medicare benefits, or who fails to enroll, will lose whatever benefits Medicare could have paid. Plan F benefits will be paid as if the individual had enrolled in Medicare.

When you or your spouse attain age 65 while covered under Plan A, B, C, E, M or P, the coverage will automatically be changed to Plan F as of the first day of the month in which you or your spouse attain age 65. You will then be billed and should make payment in the amount applicable to Plan F.

When UnitedHealthcare is notified that a disabled individual or an individual with end stage renal disease becomes eligible under Medicare while covered under Plan A, B, C, E, M or P, that individual will be moved to Plan F. The required payment rate will be adjusted accordingly. For individuals covered under Plan E, M or P, coverage will not be changed until the individual's coverage under GA-46000, the Amtrak

Early Retirement Plan, the Keolis Commuter Services (formerly MBCR) Early Retirement Plan or the TransitAmerica Services, Inc. (TASI) Early Retirement Plan ends.

To avoid undue delay in making the necessary change, immediately notify UnitedHealthcare's Railroad Administration when the individual first becomes eligible under Medicare.

If coverage for one of your Dependents is changed to Plan F because that Dependent is eligible under Medicare, and you have additional Dependents who are not eligible under Medicare, you may be able to continue coverage for those additional Dependents under Plans A, B, C, E, M or P.

Benefits under Plan A, B, C, E, M or P will cease on the date an individual is eligible to be covered under Medicare. However, such individual can become covered under Plan F.

It is important that you notify UnitedHealthcare when you or one of your Dependents becomes eligible under Medicare.

See the section entitled **When To Enroll** for important information about Medicare Advantage.

Medicare benefits are sometimes awarded on a retroactive basis. When a retroactive award is made, Medicare usually offers the individual a choice to have Medicare Part B effective currently, or retroactive to the original effective date. Part A is always made effective as of the original effective date. If a retroactive effective date for Medicare Part B is selected, the individual must pay the Medicare Part B premium for each month of retroactive coverage.

An individual who receives a retroactive award may have paid for coverage under Plans A, B, C, E, M or P between the original Medicare effective date and the date of the award. Benefits under one of those plans may have been paid. In all such cases, the individual must reimburse UnitedHealthcare for all benefits paid under Plans A, B, C, E, M or P for services rendered on or after the original Medicare effective date. The individual may choose between the following options:

1. **Elect coverage under Plan F retroactive to the original Medicare effective date. Premiums paid under any other GA- 23111 plan will be applied for Plan F coverage, and all expenses incurred will be reconsidered under Plan F.**
2. **Cancel GA-23111 coverage retroactive to the original Medicare effective date. Premiums paid under any other GA-23111 plan will be used to offset any benefits paid under the other plan. Premiums paid in excess of benefits paid will be reimbursed.**

An individual electing the second option may enroll under Plan F effective the first of the month following the month the individual notifies UnitedHealthcare of the retroactive Medicare award.

HOSPITAL EXPENSE BENEFITS

Plan F covers confinement in a Hospital provided that benefits are also payable by Part A Medicare for the confinement.

The following benefits will be paid in full during each benefit period:

- The amount of the Medicare Part A deductible for the first 60 days.
- The amount of the Medicare Part A coinsurance for each day from the 61st through the 90th day.
- The amount of the Medicare Part A coinsurance for each day that Medicare lifetime reserve days are used.

If you exhaust all Medicare Part A benefits in a benefit period, Plan F will pay 100% of the Reasonable Charge (see Definitions) for the Covered Health Services (see Definitions) provided by the Hospital for up to 365 days of Hospital confinement during your lifetime.

A benefit period is defined by Medicare. It begins on the day you are admitted to a Hospital. It ends when you have been out of a Hospital or Skilled Nursing Facility for 60 straight days. It also ends if you are in a Skilled Nursing Facility but have not received skilled care there for 60 straight days.

EXCLUSIONS

Hospital Expense Benefits are not payable for any day of confinement during which lifetime reserve days are available, but you do not use them.

Hospital Expense Benefits are not payable for any day of confinement in a Hospital which does not participate in Medicare, except when required by applicable federal or state law. In such cases, Hospital Expense Benefits will be paid as if the Hospital did participate in Medicare. For the first 90 days of the confinement, and for any days during which Medicare lifetime reserve days would otherwise be payable. Hospital Expense Benefits will be limited to the Medicare Part A deductible and coinsurance amounts described above.

Hospital Expense Benefits are not payable for any day of confinement in a psychiatric Hospital which participates in Medicare after the maximum Medicare lifetime benefit has been reached.

If charges are made for a private room, payment will be limited to the Hospital's average charge for a semi-private room.

Other exclusions that apply to this Benefit are in the General Exclusions section.

SKILLED NURSING FACILITY EXPENSE BENEFITS

Plan F covers confinement in a Skilled Nursing Facility provided that benefits are also payable by Medicare Part A for the confinement.

Payment will be made for Skilled Nursing Facility charges during a benefit period for an amount up to the Medicare Part A coinsurance for the 21st to the 100th day of confinement.

A benefit period is defined by Medicare. It begins on the day you are admitted to a Hospital. It ends when you have been out of a Hospital or Skilled Nursing Facility for 60 straight days. It also ends if you are in a Skilled Nursing Facility but have not received skilled care there for 60 straight days.

EXCLUSIONS

Skilled Nursing Facility Expenses Benefits are not payable for any day of confinement unless Medicare Part A benefits are also payable for that day, except when required by applicable federal or state law. In such cases, Skilled Nursing Facility Expense Benefits will be paid as if the Skilled Nursing Facility did participate in Medicare. For the first 20 days of the confinement, no benefits will be payable. For the next 80 days of the confinement, Skilled Nursing Facility Expense Benefits will be limited to the Medicare Part A coinsurance amounts described above.

Other exclusions that apply to this Benefit are in the General Exclusions section.

MEDICAL EXPENSE BENEFITS

Plan F covers medical care treatment which is eligible for payment under Medicare Part B.

The following amounts **will be paid in full**:

- The amount of the Medicare Part B deductible.
- The amount of the Medicare Part B coinsurance (generally 20% of the Medicare approved charges for most Medicare Part B services).
- In the event a provider does not accept a Medicare assignment, the amount over and above the amount of the Medicare approved charge, up to the amount of charge limitations set by either Medicare or state law. This amount is often referred to as "Medicare Part B excess charges".
- The amount you pay for up to three pints of blood per calendar year. This includes blood provided on an inpatient basis (covered under Medicare Part A) or an outpatient basis (covered under Medicare Part B). Charges for blood you have replaced yourself, or which was replaced by another person donating on your behalf, are not covered under this provision.

Plan F also covers medical care and treatment for certain expenses that are not eligible for payment under Medicare Part B. These Covered Expenses are listed below. They are the actual cost to you of the Reasonable Charge (see Definitions) for Covered Health Services (see Definitions) and supplies not payable by Medicare Part B listed below. The service or supply must be needed because of injury, sickness or pregnancy. Plan benefits are paid at the rate of 100% of Covered Expenses unless otherwise indicated.

Covered Expenses are:

- Government Expenses: Charges for outpatient services, and for Physician services, provided by a United States Government Hospital, when required by federal law. Benefits are paid as if the services were provided by a non-government facility and covered under Medicare.
- Medical Supplies: Charges for any supply not covered under Medicare Part B because of a specific Medicare frequency or occurrence limitation, provided the supplier is permitted to charge for that supply.
- Nursing Services: Charges of a nurse (other than one who normally resides in your home or who is a member of your immediate family) for professional services. A member of your immediate family includes you, your spouse, and the children, brothers, sisters or parents of you or your spouse. Benefits are **at the rate of 80%** of Covered Expenses, and cannot exceed $5,000 per any one person in a calendar year. These services must meet the definition of a Covered Health Service (see Definitions). They cannot be for Custodial Care (see Definitions).
- Outpatient Physical and Occupational Therapy and Speech Pathology Services: Charges which would be payable under Medicare Part B except for the Medicare annual maximum benefit for these services.
- Physician's Services: Charges for any service or supply not covered by Medicare Part B because of a specific Medicare frequency or occurrence limitation, provided the Physician is permitted to charge for that service or supply.
- Transportation Services: Transportation services to or from a Hospital in your local area. If there are no local Hospitals that can provide the care needed, transportation service to the nearest Hospital outside your local area qualified to give the required treatment will be covered.

Medical Expense Benefit will be determined at all times as if the Person Eligible Under Medicare has Full Medicare Coverage (see Definitions).

EXCLUSIONS

Other exclusions that apply to this Benefit are in the General Exclusions section.

FOREIGN EMERGENCY CARE BENEFITS

The Plan covers a percentage of Emergency Medical Care Expenses incurred while on a trip outside the United States. The Expense is the actual cost to you for the Reasonable Charges (see Definitions) for the Covered Health Services (see Definitions) described below.

Emergency Medical Care Expenses are charges you incur for any care you receive while on a trip outside the United States. The care must be needed immediately for an injury or sickness which develops in a sudden and unexpected way during your trip. The care must be for services and supplies which would have been covered under the Hospital Expense Benefits or the Medical Expense Benefits if it had been provided in the United States. It must be received during the first 60 days of your trip.

PERCENTAGE OF EMERGENCY MEDICAL CARE EXPENSES PAYABLE

The Plan pays 80% on Emergency Medical Care Expenses in a calendar year. Payment will be made in United States currency in an amount based on the bank transfer exchange rate in effect on the day the claim is processed by UnitedHealthcare.

MAXIMUM AMOUNT

The Maximum Amount payable for you or any of your Dependents is $[25,000 - 200,000]. This Maximum Amount applies to a person's entire lifetime.

EXCLUSIONS

Emergency Medical Care Expense Benefits are not payable for any expenses that are eligible for payment under Medicare.

Emergency Medical Care Expense Benefits are not payable for any expense incurred after the first 60 days of any one trip outside the United States. One trip begins on the day you leave the United States and ends on the day you return to the United States.

Other Exclusions that apply to this Benefit are in the General Exclusions section.

AT-HOME RECOVERY CARE EXPENSE

The Plan covers At-Home Recovery Care Expenses incurred for at-home assistance on a short term basis for visits for Activities of Daily Living while you are recovering from an injury or sickness.

Activities of Daily Living are bathing, dressing, personal hygiene, transferring, eating, ambulating, assistance with drugs that are normally self-administered, and changing bandages or other dressings.

Payment will be made for up to $40 per visit, for up to 7 visits in any one week, and for up to $1,600 for you or any of your covered Dependents in any one calendar year. Each visit by a member of an at-home recovery team will be considered as one visit. Four hours of At-Home Recovery Care services will be considered as one visit. If a visit exceeds four hours, each additional four hours, or part thereof, in any one 24 hour period will count as one additional visit. Each visit by any other member of an at-home recovery team will count as an additional visit.

The following conditions must be met for each visit:

- Your Physician must certify that you need At-Home Recovery Care.
- You must have been approved for Home Health Services under Medicare for the same injury or sickness.
- The visit must occur during a Medicare approved period of Home Health Care, or within 8 weeks from your last Medicare approved Home Health Care visit.
- The visit is not paid for by Medicare or any other government program.
- The visit is not covered under the Medical Expense Benefits under the description of Nursing Services.
- The visit is provided by a Care Provider (see definition below).
- The visit is not provided by a member of your immediate family - comprising the Employee, the Employee's wife or husband, and the children, brothers, sisters and parents of either the Employee or the Employee's wife or husband.
- The visit is not provided by an unpaid volunteer.
- The visit occurs in your home. Your home is any place used by you as a place of residence, provided that such place would qualify as a residence for Home Health Care Services covered by Medicare. A Hospital or Skilled Nursing Facility would not be considered your home.

A Care Provider is a duly qualified or licensed Home Health Aide, Homemaker, Personal Care Aide or Nurse provided through a licensed home health care agency or referred by a licensed referral agency or licensed nurses registry.

A Home Health Aide, Homemaker or Personal Care Aide is a person who provides personal care services. If state or local licensing is required, the person must be licensed as a home health aide, homemaker or personal care aide where service is performed. If licensing is not required, any person who meets the minimum training qualifications recognized by the National Home Caring Council, National League of Nursing or Health Care Financing Administration will be considered a Home Health Aide, Homemaker or Personal Care Aide.

A Nurse is a professional nurse legally designated "RN" (Registered Nurse) or "LPN" (Licensed Practical Nurse) who, where licensing is required, holds a valid license from the state in which the nursing service is performed. "LPN" shall include a licensed vocational nurse ("LVN") and any other similarly designated nurse in those jurisdictions in which a professional nurse is designated as other than a "LPN", and for whom licensing is required.

EXCLUSIONS

Other Exclusions that apply to this Benefit are in the General Exclusions section.

PREVENTIVE MEDICAL CARE EXPENSE BENEFITS

The Plan covers Preventive Medical Care Expenses.

Preventive Medical Care Expenses are the following:

- An annual clinical preventive medical history and physical examination and patient education to address preventive health care measures.
- Any of the following preventive screening tests or preventive services approved by your Physician:
  - fecal occult blood test and/or digital rectal examination;
  - mammogram;
  - dipstick urinalysis for hematuria, bacteriuria and proteinuria;
  - pure tone (air only) hearing screening test;
  - serum cholesterol screening, but only once in every five year period;
  - thyroid function test;
  - diabetes screening;
  - prostate cancer screening;
  - colorectal cancer screening.
- Influenza vaccine administered at any appropriate time during the year.
- Tetanus and diphtheria booster once in every ten year period.
- Any other test or preventive measures determined appropriate by your Physician.

Benefits will be paid for the actual cost to you for the Reasonable Charges (see Definitions), up to $[100 – 2,000] in a calendar year for you or any of your Dependents.

EXCLUSIONS

Preventive Medical Care Expense Benefits are not payable for any service or supply covered by Medicare.

Other exclusions that apply to this Benefit are in the General Exclusions section.

TREATMENT CENTER EXPENSE BENEFITS

FOR ALCOHOLISM AND CHEMICAL DEPENDENCY

The Plan covers confinement of you or your covered Dependent in a Treatment Center because of alcoholism and/or chemical dependency when such dependency has been certified by a Physician or Psychologist and the confinement has been prescribed.

Payment will be made for the Reasonable Charges made by the Treatment Center for room, board, care and treatment for any one person, up to a calendar year maximum of 60 days.

Detoxification services will be covered for up to 12 days annually.

VIII

PLAN M

APPLICABLE TO PERSONS ELIGIBLE UNDER THE KEOLIS COMMUTER SERVICES (FORMERLY MBCR) EARLY RETIREMENT PLAN

Eligibility

This Plan has been developed to supplement the benefits for retired and disabled railroad Employees and their Dependents who qualify for coverage under the Keolis Commuter Services (formerly MBCR) Early Retirement Plan.

If you qualify for coverage under the Keolis Commuter Services (formerly MBCR) Early Retirement Plan you may enroll for Employee and/or Dependents benefits under Plan M provided your enrollment and payment are mailed (postmarked) to UnitedHealthcare on or before the last day of the month in which coverage under the Keolis Commuter Services (formerly MBCR) health plan for active employees terminates or in the next three calendar months.

When coverage for you or any family member terminates under the Keolis Commuter Services (formerly MBCR) Early Retirement Plan, you are no longer eligible for Plan M. You must notify UnitedHealthcare immediately when this occurs.

If you or a family member qualifies for Medicare due to age (65), your coverage under Plan M will be automatically transferred to Plan F.

If you or a family member becomes eligible for Medicare for any other reason you must notify UnitedHealthcare immediately.

MAJOR MEDICAL EXPENSE BENEFITS

The following benefits are payable only for services which are considered out-of-network under the Keolis Commuter Services (formerly MBCR) Early Retirement Plan or when the lifetime maximium under the Keolis Commuter Services (formerly MBCR) Early Retirement Plan has been exhausted. No benefits are payable under Plan M for In-network services.

PLAN M CLAIM DETERMINATIONS

Both the Cooperating Railway Labor Organizations, who are the policyholder under GA-23111, and UnitedHealthcare, desire a consistency in coverage under the Keolis Commuter Services (formerly MBCR) Early Retirement Plan and Plan M. However, there are some services covered under the Keolis Commuter Services (formerly MBCR) Early Retirement Plan which are not covered under Plan M. See the section entitled “Covered Services”.

The sections below entitled “Preferred Providers” and “Care Coordiantion” apply only when the lifetime maximum has been exhausted under the Keolis Commuter Services (formerly MBCR) Early Retirement Plan.

DEDUCTIBLE

The Deductible is separate for you and each of your Dependents each calendar year. It has two parts - a Basic Benefits Deductible and a Cash Deductible.

Basic Benefits Deductible

The Basic Benefits Deductible is the total payments made during the calendar year under the Keolis Commuter Services (formerly MBCR) Early Retirement Plan or, if the benefits under the Keolis Commuter Services (formerly MBCR) Early Retirement Plan are reduced in accordance with its Coordination of Benefits provisions, the payments which would have been made had such reduction not occurred.

Cash Deductible

The Cash Deductible is $[100 – 500].

PERCENTAGE OF COVERED EXPENSES PAYABLE

The Plan pays [60 – 80]% (75% for the first 40 outpatient visits for alcoholism, chemical dependency and/or mental illness, and 60% for any visits thereafter) of the Covered Expenses in a calendar year after the Deductible is satisfied.

The Plan pays 100% of the Covered Expenses in a calendar year after the Out-of-Pocket Maximum is met.

OUT-OF-POCKET MAXIMUM

The Out-of-Pocket Maximum limits the amount of Covered Expenses you will have to pay for any one covered individual in a calendar year. The Out-of-Pocket Maximum each calendar year is [$5,000 - $15,000]. Covered Expenses used to satisfy your Deductible are also used to help satisfy your Out-of-Pocket Maximum.

The following expenses do not count in determining if any Out-of-Pocket Maximum has been met:

- Charges you pay that are in excess of the Reasonable Charge.
- Charges you pay that are in excess of specific Plan limitations or exclusions.
- Charges you pay for expenses not covered by the Plan.
- The [$500 (or any part thereof)] reduction in benefits under the Keolis Commuter Services (formerly MBCR) Early Retirement Plan if the required notification is not made.
- Co-payments you make and any other charges you pay under the Keolis Commuter Services (formerly MBCR) Early Retirement Plan Managed Pharmacy Services Benefit.

MAXIMUM AMOUNT

The Maximum Amount payable with respect to you or any one of your Dependents is [$300,000 - $1,000,000]. This Maximum Amount applies to a person's entire lifetime.

COVERED EXPENSES

Covered Expenses are the actual cost to you of the Reasonable Charges (see Definitions) for the Covered Health Services (see Definitions) listed below. The service or supply must be needed because of injury, sickness or pregnancy.

A service or supply is not a Covered Health Service just because it is furnished by, or ordered by, your provider. The services and supplies will be reviewed by UnitedHealthcare to determine if they are covered under the Plan.

The services and supplies for which Covered Expenses may be incurred are as follows:

Ambulatory Surgical Center Services

Services given within 72 hours before or after a surgical procedure. The services have to be given in connection with the procedure.

Anesthetics

Applied Behavioral Analysis Services

Applied Behavioral Analysis (ABA) services for Autism Spectrum Disorders that are:

- Focused on the treatment of core deficits of Autism Spectrum Disorder;
- Provided by a *Board Certified Applied Behavioral Analyst (BCBA)* or other qualified provider under the appropriate supervision; and
- Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property, and impairment in daily functioning.
- Services include the following:
- Diagnostic evaluations, assessment and treatment planning.
- Treatment and/or procedures.
- Medication management and other associated treatments.
- Individual, family, and group therapy.
- Provider-based case management services.
- Crisis intervention.

Birth Center Services

Chemotherapy

Clinical Trials

Routine patient care costs incurred during participation in an approved clinical trial meeting the approved clinical trial criteria stated below.

Benefits include the reasonable and necessary items and services used to diagnose and treat complications arising from participation in an approved clinical trial.

Benefits are available only when the Covered Family Member is clinically eligible for participation in the clinical trial as defined by the researcher. Benefits are not available for preventive clinical trials.

Routine patient care costs for clinical trials include:

- Covered Health Services for which benefits are typically provided absent a clinical trial.
- Covered Health Services required solely for the provision of the investigational item or service, the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications.
- Covered Health Services needed for reasonable and necessary care arising from the provision of an investigational item or service.

Routine costs for clinical trials do not include:

- The Experimental or Investigational Service or item. The only exceptions to this are:
  - Certain Category B devices.
  - Certain promising interventions for patients with terminal illnesses.
  - Other items and services that meet specified criteria in accordance with our medical policy guidelines.
- Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.
- Items and services provided by the research sponsors free of charge for any person enrolled in the trial.

To be an approved clinical trial, a clinical trial must meet all of the following criteria:

- Be approved and funded in full or in part by one or more of the following:
  - National Institutes of Health (NIH). (Includes National Cancer Institute (NCI).)
  - Centers for Disease Control and Prevention (CDC).
  - Agency for Healthcare Research and Quality (AHRQ).
  - Centers for Medicare and Medicaid Services (CMS).
  - A bona fide clinical trial cooperative group, including the National Cancer Institute Clinical Trials Cooperative Group, the National Cancer Institute Community Clinical Oncology Program, the AIDS Clinical Trials Group, and the Community Programs for Clinical Research in AIDS.
  - The Department of Defense (DOD), the Department of Veterans Affairs, or the Department of Energy, or a qualified nongovernmental research entity to which the National Cancer Institute has awarded a support grant.
  - A study or investigation approved by the Food and Drug Administration (FDA), including those conducted under an investigational new drug or device application reviewed by the FDA.
  - An investigation or study approved by an Institutional Review Board registered with the Department of Health and Human Services that is associated with an institution that has a federal-wide assurance approved by the Department of Health and Human Services specifying compliance with federal regulations.
- The clinical trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (IRBs) before participants are enrolled in the trial. We may, at any time, request documentation about the trial to confirm that the clinical trial meets current standards for scientific merit and has the relevant IRB approvals.

The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Service and is not otherwise excluded under the Policy.

Durable Medical Equipment

Durable Medical Equipment means equipment that meets all of the following criteria:

- It is for repeated use and is not consumable or disposable
- It is used primarily for a medical purpose.
- It is appropriate for use in the home.

Some examples of durable medical equipment are:

- Appliances that replace a lost body organ or part or help an impaired one to work.
- Orthotic devices such as arm, leg, neck and back braces.
- Hospital-type beds.
- Equipment needed to increase mobility, such as a wheelchair.
- Respirators or other equipment for the use of oxygen.
- Monitoring devies.

Care Coordination must be contacted for any purchase or rental costs which exceed [$1,000]. Care Coordination will determine whether the purchase or rental of the equipment is Medically Appropriate.

Diabetes Treatment

Coverage for diabetic equipment, diabetes supplies and in-person outpatient diabetic self-management training and education programs (including medical nutrition therapy) when provided under the direction of a Physician by certified, registered or licensed health care professional.

Diabetes self-management training includes training provided to a Covered Person after the initial diagnosis in the care and management of that condition, including nutritional counseling and proper use of diabetes equipment and supplies. Coverage is also provided for additional training upon diagnosis of a significant change in medical condition that requires a change in the self-management regime, and a periodic continuing education training as warranted by the development of new techniques and treatment for diabetes.

Habilitative Services

Habilitative Services for children from birth to age 21 are covered, except for Habilitative Services provided in early intervention and school services.

Habilitative Services includes services, including occupational therapy, physical therapy, and speech therapy, for the treatment of a child with a congenital or genetic birth defect to enhance the child's ability to function. For purposes of Habilitaitive Services, a cogenital or genetic birth defect means a defect existing at or from birth, including a hereditary defect. A congential or genetic birth defect includes, but is not limited to (a) autism or autism spectrum disorder, and (b) cerebral palsy.

Home Health Care Agency Services

- Part-time or intermittent nursing care rendered by or supervised by a registered nurse.
- Part-time or intermittent care by a home health aide.

- Physical therapy or occupational therapy.
- Speech therapy to restore speech lost or impaired due to removal of vocal cords, cerebral thrombosis, or brain damage due to injury or organic brain lesion.
- Prescription drugs
- Medical Supplies.
- X-rays and laboratory tests.

Hospice Care Services

Up to a maximum payment of [$3,000] for each Course of Care for room, board, care and treatment charged by a Hospice.

Up to a maximum payment of [$1,000] for each Course of Care for:

- Counseling for the patient's Immediate Family. Services must be given by a licensed social worker or a licensed pastoral counselor.
- Bereavement counseling up to [15] visits for the patient's Immediate Family. Services must be given by a licensed social worker or a licensed pastoral counselor and given within six months after the patient's death.

The Physician must certify that the patient is terminally ill with 6 months or less to live.

"Immediate Family" means you or any member of your family who is covered under this Plan.

"Course of Care" means all services given to the patient and the patient's Immediate Family in connection with the terminal illness of the patient.

Services provided by a licensed pastoral counselor to a member of his/her congregation in the course of his/her normal duties as a pastor or minister will not be considered a Covered Expense.

Hospital Services

Services and supplies provided by a Hospital on an inpatient or outpatient basis.

If charges are made for a private room, Covered Expenses will be limited to the hospital's average daily charge for a semi-private room.

Coverage is also provided for up to 60 inpatient days per calendar year for alcoholism, chemical dependency and/or mental illness services. In addition, coverage is provided for up to 12 days per calendar year for inpatient detoxification services.

Coverage is also provided for newborn infant hearing screenings and all necessary audiological examinations provided as recommended by the National Joint Committee on Infant Hearing. For purposes of this coverage, "Hospital" shall include birthing centers or other centers having newborn nurseries.

Services and supplies provided by a Hospital for emergency care and treatment for a medical emergency, including the sudden onset or worsening of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent lay person, who possesses an average knowledge of health and medicine to result in:

- Placing the patient's health in serious jeopardy;
- Serious impairment to bodily functions; or

- Serious dsyfunction of any bodily organ or part.

Coverage is also provided for a voluntary HIV screening test performed while receiving emergency care in a Hospital, once per calendar year, regardless of whether or not the HIV screening is necessary for the treatment of the condition for which the emergency care is sought.

Infertility Treatment

Diagnosis and treatment of infertility, including surgery and drug therapy. This does not include procedures or services to facilitate a pregnancy, such as, but not limited to, in vitro fertilization, embryo transfer, artificial insemination and immunotherapy for infertility.

Medical Supplies

- Surgical supplies (such as bandages and dressings). Supplies given during surgery or a diagnostic procedure are included in the overall cost for that surgery or diagnostic procedure.
- Blood or blood plasma only if not donated or replaced.

Nursing Services

Services of a trained nurse or a Nurse-Midwife.

Occupational Therapy

Services of a licensed occupational therapist provided the following conditions are met:

- The therapy must be ordered and monitored by a Physician.
- The therapy must be given in accordance with a written treatment plan approved by a Physician. The therapist must submit progress reports to the Physician at the intervals stated in the treatment plan.
- The therapy must be expected to result in significant, objective, measurable physical improvement within two (2) months of the start of treatment.

Organ/Tissue Transplants

- Donor Charges

  In the case of an organ or tissue transplant, no services or supplies for the donor are considered Covered Health Services unless the recipient is the Employee or his/her Dependent. If the recipient is not the Employee or his/her Dependent, no benefits are payable for donor charges.

  The search for bone marrow/stem cell from a donor who is not biologically related to the patient is not considered a Covered Health Service UNLESS the search is made in connection with a transplant procedure arranged by a Transplant Facility.

- Qualified Procedures

  If a qualified procedure, listed below, is Medically Appropriate, the “Medical Care and Treatment” provisions set forth below apply:

  - Heart transplants
  - Heart/lung transplants
  - Liver transplants
  - Kidney transplants
  - Pancreas transplants
  - Kidney/pancreas transplants

- Bone marrow/stem cell transplants
- Other transplant procedures when UnitedHealthcare determines that it is necessary to perform the procedure at a Treatment Facility.

- Medical Care and Treatment
  - The following services provided in connection with the transplant are Covered Health Services:
    - Pre-transplant evaluation for one of the procedures listed above
    - Organ acquisition and procurement
    - Hospital and Physician fees
    - Transplant procedures
    - Follow-up care for a period up to one year after the transplant
    - Search for bone marrow/stem cell from a donor who is not biologically related to the patient. If a separate charge is made for a bone marrow/stem cell search, a maximum benefit of $25,000 is payable for all charges made in connection with the search.

- Transportation and Lodging

  The following benefits for transportation and lodging expenses are available for those Medically Appropriate Qualified Procedures, as listed above, that are performed at a Transplant Facility. If a Transplant Facility is not used, then these transportation and lodging benefits will not be covered.

  Care Coordination will assist the patient and family with travel and lodging arrangements. Expenses for travel, lodging and meals for the transplant recipient and a companion are available under this Plan as follows:

  - Reasonable and necessary expenses for transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of the transplant for the purposes of an evaluation, the transplant procedure or necessary post-discharge follow-up.
  - Reasonable and necessary expenses for lodging and meals for the patient (while not confined) and one companion. Benefits are paid at a per diem rate of up to $50 for one person or up to $100 for two people.

  Travel and lodging expenses are only available if the transplant recipient resides more than 50 miles from the Transplant Facility.

  If the Dependent who is the patient is a minor child, the transportation expenses of two companions will be covered and lodging and meal expenses will be reimbursed up to the $100 per diem rate.

  There is a combined overall lifetime maximum of $10,000 per Employee or Dependent for all transportation, lodging and meal expenses incurred by the transplant recipient and companion(s) and reimbursed under this Plan M [and Plans A, B and/or C, combined], in connection with all transplant procedures.

Outpatient Alcholism, Chemical Dependency and Mental Illness Services

Benefits for outpatient services to treat alcoholism, chemical dependency and/or mental illness. The Plan pays 75% of the Covered Expenses in a calendar year after the Deductible is satisfied, for the first 40 outpatient visits, and then 60% of any additional visits.

Physical Therapy

Services of a licensed physical therapist, provided the following conditions are met:

- The therapy must be ordered and monitored by a Physician.
- The therapy must be given in accordance with a written treatment plan approved by a Physician.
- The therapist must submit progress reports to the Physician at the intervals stated in the treatment plan.

The therapy must be expected to result in significant, objective, measurable physical improvement within two months of the start of the treatment.

In addition, benefits for physical therapy for Dependent children, under the age of 21, with congenital or birth defects (including autism and cerebral palsy) will be covered.

Physicians Services

Prescription Contraceptive Devises

Devices approved by the U.S. Food and Drug Administration for the prevention of a pregnancy are covered for female employees and the wives of male employees.

Prescription Drugs

Prescription Drugs other than those obtained from a retail pharmacy or by mail order.

Preventive Adult Health Services

- Benefits are available for mammography testing that is consistent with the recommendations of governmental scientific agencies. Benefits for mammography testing are payable when mammography testing is performed as follows:
    - a baseline mammogram; and
    - follow-up mammograms on an annual basis.
- Pap smears are covered annually, or when it is determined by the attending physician that the test is necessary.

The preventive services listed above are not subject to coinsurance or the Calendar Year Deductible.

- Colorectal cancer screenings are covered in compliance with the American Cancer Society colorectal cancer screenings guidelines.
- Screenings in accordance with the latest screening guidelines issued by the American Cancer Society.

Preventive Child Health Services

Benefits are available from birth to age 21 including:

- Coverage for injury or sickness, including the necessary care and treatment of medically diagnosed congenital defects, birth abnormalities, and prematurity; and
- Coverage for preventive and primary care services, including physician examinations, measurements, sensory screening, neuropsychiatric evaluation, and development screening, which coverage shall include unlimited visits up to the age of 12 years, and 3 visits per year for minor children ages 12 years up to age 21 years of age. Preventive and primary care services shall also include, as recommended by the physician, hereditary and metabolic screening at birth, immunizations, urinalysis, tuberculin tests, and hematocrit, hemoglobin, and other appropriate blood tests, including tests to screen for sickle hemoglobinopathy.

Psychologist Services

Radiation Therapy

Skilled Nursing Facility Care After Hospital Confinement

Services and supplies up to 31 days of confinement following each Hospital confinement.

Separate confinements for the same cause are considered to be one confinement, unless separated by 14 or more days.

If charges are made for a private room, Covered Expenses will be limited to the facility's daily charge for a semi-private room.

Speech Therapy

These services must be given to restore speech. The speech must have been lost or impaired due to one of the following:

- Removal of vocal cords.
- Cerebral thrombosis (cerebral vascular accident).
- Brain damage due to injury or organic brain lesion (aphasia).

The therapy must be expected to result in significant, objective, measurable physical improvement within two months of the start of the treatment.

In addition, benefits for speech therapy for Dependent children, under the age of 21, with congenital or birth defects (including autism and cerebral palsy) will be covered.

Spinal Manipulations

Services of a physician given for the detection or correction (manipulation) by manual ormechanical means of structural imbalance or distortion in the spine.

No benefits are available for any type of therapy, service or supply, including, but not limited to, spinal manipulation by a chiropractor or other physician once the therapy, service or supply ceases to be therapeutic and is instead administered to maintain a level of functioning or to prevent a medical problem from occuring or reoccuring.

Telehealth

Charges for services provided through telehealth rather than face-to-face consultation when the services can appropriately be provided through telehealth.

- "Telehealth" means the use of live, interactive audio and visual transmissions of a physician-patient encounter from one site to another using telecommunications technologies. They may include transmissions of real-time telecommunications or those transmitted by store-and-forward technology.

- Telemedicine services are medical services provided via interactive audio, video or other electronic media for the purpose of diagnosis, consultation, or treatment that do not involve direct, in-person patient contact.

Treatment Center Services

Charges for services at a Treatment Center when a Physician or Psychologist has certified an alcoholism or chemical dependency and has prescribed such services, up to a calendar year maximum of 60 days. In addition, detoxification services will be covered for up to 12 days annually.

Transportation Services

Transportation charges are covered for transportation to a Hospital in an emergency.

The transportation services must be to a Hospital in your local area. If there are no local Hospitals that can provide the care needed, charges for transportation to the nearest Hospital outside your local area qualified to give the required treatment, will be covered.

X-ray and Laboratory Tests

EXCLUSIONS

Major Medical Expenses Benefits are not payable for expenses for:

- Expenses for any confinement, treatment, services or supplies which would have been payable under the Keolis Commuter Services (formerly MBCR) Early Retirement Plan, but which were not payable due to you or your Dependent's non-compliance with the medical management provisions described under the Keolis Commuter Services (formerly MBCR) Early Retirement Plan.

- Prescription Drugs purchased from a pharmacy or by mail order.

Other exclusions that apply to this Benefit are in the General Exclusions section.

PREFERRED PROVIDERS

UnitedHealthcare has arranged with certain health care providers to become Preferred Providers. These Preferred Providers have agreed to discount their charges for Covered Expenses.

If Preferred Providers are used, the amount of Covered Expenses for which you are responsible will generally be less than the amount owed if other providers had been used. The percentage of Covered Expenses payable remains the same whether or not Preferred Providers are used. However, because the Covered Expenses may be less when Preferred Providers are used, the portion that you owe will be less.

You will receive an Identification Card showing that you and/or your Dependents covered under Plan M are entitled to these discounts. This Identification Card must be shown every time health care services are given. This is how the provider knows that you and/or your Dependent is covered under a Preferred Provider plan. Otherwise, you could be billed for the provider's normal charge.

Call UnitedHealthcare at 1-800-842-5252 to inquire about or locate Preferred Providers in your area. You may also access Preferred Provider information online at myuch.com.

Preferred Providers are responsible for filing your claims directly to UnitedHealthcare. You do not need to submit claims for Preferred Providers services or supplies.

You must submit claims for services and supplies rendered by other providers as described in the Claim Information section.

If a Preferred Provider bills you for any part of the discount amount, call UnitedHealthcare at 1-800-842-5252 for assistance.

CARE COORDINATION

Notification

UnitedHealthcare's Care Coordination must be contacted for the following services:

- Inpatient facility admissions
- Reconstructive procedures
- Maternity Services (if stay exceeds the 48/96 guidelines)
- Transplant services
- [Gender transformation surgery]

How to Notify Care Coordination

Care Coordination is notified by calling toll-free 1-800-842-4555. Their working days are Monday through Friday, except for State and Federal holidays. The hours of operation are 8:00 a.m. to 7:00 p.m. However, you can call Care Coordination at any time, day, or night. If you call outside the hours of operation, you may leave a message with your telephone number on an answering machine, and a Care Coordination representative will return your call within one working day.

When to Notify Care Coordination

Care Coordination should be notified as promptly as possible before any of the services listed above are rendered. The notification allows Care Coordination sufficient time to complete a review before the services are rendered. Otherwise, if Care Coordination does not receive sufficient advance notice, they may not be able to complete the review before you incur expenses.

For an emergency which results in a confinement, you (or a representative or your Physician) must call Care Coordination within two days (excluding weekends and holidays) of the date the confinement begins.

You should notify Care Coordination promptly after you become aware that you are pregnant. You must notify Care Coordination only if the inpatient care for the mother or child is expected to continue beyond:

- 48 hours following a normal vaginal delivery, or
- 96 hours following a cesarean section.

What Care Coordination Does

Care Coordination reviews the services you are to receive with your Physician, and agrees on a treatment plan. If there is disagreement between Care Coordination and your Physician, a Care Coordination Physician Advisor may be involved.

If there is still not agreement on a treatment plan, you and your Physician always make the final decision.

Effect on Benefits

If Care Coordination is not notified when required, benefits otherwise payable at 70% will be paid at 60%. If your Out-of-Pocket Maximum has been met, the Plan will pay 100% of Covered Expenses even if Care Coordination is not notified. If your benefits are reduced from 70% to 60% because Care Coordination is not notified when required, the full 40% you pay will be applied to your Out-of-Pocket Maximum.

The Plan pays a percentage of Covered Expenses incurred in calendar year which exceed the Deductible.

Remember: This notice obligation is your responsibility. It is not the responsibility of your Physician, your Hospital, or any other provider to make the required notification to Care Coordination. However, your Physician, Hospital, or other provider may make this notice for you.

Other exclusions that apply to this Benefit are in the General Exclusions section.

IX

PLAN P

APPLICABLE TO PERSONS ELIGIBLE UNDER THE AMTRAK EARLY RETIREMENT PLAN AND THE TRANSITAMERICA SERVICES, INC. (TASI) EARLY RETIREMENT PLAN

ELIGIBILILTY

This Plan has been developed to supplement the benefits for retired and disabled railroad Employees and their Dependents who qualify for coverage under the Amtrak Early Retirement Plan or the TransitAmerica Services, Inc. (TASI) Early Retirement Plan.

If you qualify for coverage under the Amtrak Early Retirement Plan or the TransitAmerica Services, Inc. (TASI) Early Retirement Plan, you may enroll for Employee and/or Dependent benefits under Plan P provided your enrollment and payment are mailed (postmarked) to UnitedHealthcare on or before the last day of the month in which coverage under the Amtrak Early Retirement Plan or TransitAmerica Services, Inc. (TASI) Plan terminates or in the next three calendar months.

When coverage for you or any family member terminates under the Amtrak Early Retirement Plan or the TransitAmerica Services, Inc. (TASI) Early Retirement Plan, you are no longer eligible for Plan P. You must notify UnitedHealthcare immediately when this occurs.

If you or a family member qualifies for Medicare due to age (65), your coverage under Plan P will be automatically transferred to Plan F.

If you or a family member becomes eligible for Medicare for any other reason, you must notify UnitedHealthcare immediately.

MAJOR MEDICAL EXPENSE BENEFITS

The Plan pays [60% - 80%] (75% for the first 40 outpatient visits for alcoholism, chemical dependency and/or mental illness and 60% for any visits thereafter) of the Covered Expenses incurred in a calendar year which exceed the Deductible.

DEDUCTIBLE

The Deductible is separate for you and each of your Dependents each calendar year. It has two parts - a Basic Benefits Deductible and a Cash Deductible.

Basic Benefits Deductible

The Basic Benefits Deductible is the total payments made during the calendar year under the Amtrak Early Retirement Plan or the TransitAmerica Services, Inc. Plan or, if the benefits under the Amtrak Early Retirement Plan or the TransitAmerica Services, Inc. (TASI) Early Retirement Plan are reduced in accordance with its Coordination of Benefits provisions, the payments which would have been made had such reduction not occurred.

Cash Deductible

The Cash Deductible is $[100 – 500].

PERCENTAGE OF COVERED EXPENSES PAYABLE

The Plan pays [60–80]% (75% for the first 40 outpatient visits for alcoholism, chemical dependency and/or mental illness and 60% for any visits thereafter) of Covered Expenses in a calendar year after the Deductible is satisfied.

The Plan pays 100% of the Covered Expenses in a calendar year after the Out-of-Pocket Maximum is met.

OUT-OF-POCKET MAXIMUM

The Out-of-Pocket Maximum limits the amount of Covered Expenses you will have to pay for any one covered individual in a calendar year. The Out-of-Pocket Maximum each calendar year is $[5,000 – 15,000]. Covered Expenses used to satisfy your Deductible are also used to help satisfy your Out-of-Pocket Maximum.

The following expenses do not count in determining if any Out-of-Pocket Maximum has been met:

- Charges you pay that are in excess of the Reasonable Charge.
- Charges you pay that are in excess of specific Plan limitations or exclusions.
- Charges you pay for expenses not covered by the Plan.
- Charges you pay as a result of a reduction in benefits under the Amtrak Early Retirement Plan or the TransitAmerica Services, Inc. (TASI) Early Retirement Plan if any required medical management notification is not made, or if medical management determines that the service or supply is not a Covered Health Service as that term is defined under the Amtrak Early Retirement Plan or the TransitAmerica Services, Inc. (TASI) Early Retirement Plan.
- Co-payments you make and any other charges you pay under the Amtrak Early Retirement Plan or the TransitAmerica Services, Inc. (TASI) Early Retirement Plan prescription drug benefit.

MAXIMUM AMOUNT

The Maximum Amount payable with respect to you or any one of your Dependents is $[300,000 – 1,000,000]. This Maximum Amount applies to a person's entire lifetime.

COVERED EXPENSES

Covered Expenses are the actual cost to you of the Reasonable Charges (see Definitions) for the Covered Health Services (see Definitions) listed below. The service or supply must be needed because of injury, sickness or pregnancy.

A service or supply is not a Covered Health Service just because it is furnished by, or ordered by, your provider. The services and supplies will be reviewed by UnitedHealthcare to determine if they are covered under the Plan.

The services and supplies for which Covered Expenses may be incurred are as follows:

Ambulatory Surgical Center Services

Services given within 72 hours before or after a surgical procedure. The services have to be given in connection with the procedure.

Anesthetics

Applied Behavioral Analysis Services

Applied Behavioral Analysis (ABA) services for Autism Spectrum Disorders that are:

- Focused on the treatment of core deficits of Autism Spectrum Disorder;
- Provided by a *Board Certified Applied Behavioral Analyst (BCBA)* or other qualified provider under the appropriate supervision; and
- Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property, and impairment in daily functioning.
- Services include the following:
- Diagnostic evaluations, assessment and treatment planning.
- Treatment and/or procedures.
- Medication management and other associated treatments.
- Individual, family, and group therapy.
- Provider-based case management services.
- Crisis intervention.

Birth Center Services

Chemotherapy

Clinical Trials

Routine patient care costs incurred during participation in an approved clinical trial meeting the approved clinical trial criteria stated below.

Benefits include the reasonable and necessary items and services used to diagnose and treat complications arising from participation in an approved clinical trial.

Benefits are available only when the Covered Family Member is clinically eligible for participation in the clinical trial as defined by the researcher. Benefits are not available for preventive clinical trials.

Routine patient care costs for clinical trials include:

- Covered Health Services for which benefits are typically provided absent a clinical trial.
- Covered Health Services required solely for the provision of the investigational item or service, the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications.
- Covered Health Services needed for reasonable and necessary care arising from the provision of an investigational item or service.

Routine costs for clinical trials do not include:

- The Experimental or Investigational Service or item. The only exceptions to this are:
  - Certain Category B devices.
  - Certain promising interventions for patients with terminal illnesses.
  - Other items and services that meet specified criteria in accordance with our medical policy guidelines.
- Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.
- Items and services provided by the research sponsors free of charge for any person enrolled in the trial.

To be an approved clinical trial, a clinical trial must meet all of the following criteria:

- Be approved and funded in full or in part by one or more of the following:
  - National Institutes of Health (NIH). (Includes National Cancer Institute (NCI).)
  - Centers for Disease Control and Prevention (CDC).
  - Agency for Healthcare Research and Quality (AHRQ).
  - Centers for Medicare and Medicaid Services (CMS).
  - A bona fide clinical trial cooperative group, including the National Cancer Institute Clinical Trials Cooperative Group, the National Cancer Institute Community Clinical Oncology Program, the AIDS Clinical Trials Group, and the Community Programs for Clinical Research in AIDS.
  - The Department of Defense (DOD), the Department of Veterans Affairs, or the Department of Energy, or a qualified nongovernmental research entity to which the National Cancer Institute has awarded a support grant.
  - A study or investigation approved by the Food and Drug Administration (FDA), including those conducted under an investigational new drug or device application reviewed by the FDA.
  - An investigation or study approved by an Institutional Review Board registered with the Department of Health and Human Services that is associated with an institution that has a federal-wide assurance approved by the Department of Health and Human Services specifying compliance with federal regulations.
- The clinical trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (IRBs) before participants are enrolled in the trial. We may, at any time, request documentation about the trial to confirm that the clinical trial meets current standards for scientific merit and has the relevant IRB approvals.

The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Service and is not otherwise excluded under the Policy.

Diabetes Treatment

Coverage for diabetic equipment, diabetes supplies and in-person outpatient diabetic self-management training and education programs (including medical nutrition therapy) when provided under the direction of a Physician by a certified, registered or licensed health care professional.

Diabetes self-management training includes training provided to a Covered Person after the initial diagnosis in the care and management of that condition, including nutritional counseling and proper use of diabetes equipment and supplies. Coverage is also provided for additional training upon diagnosis of a significant change in medical condition that requires a change in the self-management regime, and a periodic continuing education training as warranted by the development of new techniques and treatment for diabetes.

Durable Medical Equipment

Durable Medical Equipment means equipment that meets all of the following criteria:

- It is for repeated use and is not consumable or disposable.
- It is used primarily for a medical purpose.
- It is appropriate for use in the home.

Some examples of durable medical equipment are:

- Appliances that replace a lost body organ or part or help an impaired one to work.
- Orthotic devices such as arm, leg, neck and back braces.
- Hospital-type beds.
- Equipment needed to increase mobility, such as a wheelchair.
- Respirators or other equipment for the use of oxygen.
- Monitoring devices.

Care Coordination must be contacted for any purchase or rental costs which exceed [$1,000]. Care Coordination will determine whether the purchase or rental of the equipment is Medically Appropriate.

Habilitative Services

Habilitative Services for children from birth to age 21 are covered, except for Habilitative Services provided in early intervention and school services.

Habilitative Services includes services, including occupational therapy, physical therapy, and speech therapy, for the treatment of a child with a congenital or genetic birth defect to enhance the child's ability to function. For purposes of Habilitaitive Services, a cogenital or genetic birth defect means a defect existing at or from birth, including a hereditary defect. A congential or genetic birth defect includes, but is not limited to (a) autism or autism spectrum disorder, and (b) cerebral palsy.

Home Health Care Agency Services

- Part-time or intermittent nursing care rendered by or supervised by a registered nurse.
- Part-time or intermittent care by a home health aide.
- Physical therapy or occupational therapy.
- Speech therapy to restore speech lost or impaired due to removal of vocal cords, cerebral thrombosis, or brain damage due to injury or organic brain lesion.
- Prescription Drugs.
- Medical Supplies.
- X-rays and laboratory tests.

Hospice Care Services

Up to a maximum payment of [$3,000] for each Course of Care for room, board, care and treatment charged by a Hospice.

Up to a maximum payment of [$1,000] for each Course of Care for:

- Counseling for the patient's Immediate Family. Services must be given by a licensed social worker or a licensed pastoral counselor.
- Bereavement counseling up to [15] visits for the patient's Immediate Family. Services must be given by a licensed social worker or a licensed pastoral counselor and given within six months after the patient's death.

The Physician must certify that the patient is terminally ill with 6 months or less to live.

"Immediate Family" means you or any member of your family who is covered under this Plan.

"Course of Care" means all services given to the patient and the patient's Immediate Family in connection with the terminal illness of the patient.

Services provided by a licensed pastoral counselor to a member of his/her congregation in the course of his/her normal duties as a pastor or minister will not be considered a Covered Expense.

Hospital Services

Services and supplies provided by a Hospital on an inpatient or outpatient basis.

If charges are made for a private room, Covered Expenses will be limited to the hospital's average daily charge for a semi-private room.

Coverage is also provided for up to 60 inpatient days per calendar year for alcoholism, chemical dependency and/or mental illness services. In addition, coverage is provided for up to 12 days per calendar year for inpatient detoxification services.

Coverage is also provided for newborn infant hearing screenings and all necessary audiological examinations provided as recommended by the National Joint Committee on Infant Hearing. For purposes of this coverage, "Hospital" shall include birthing centers or other centers having newborn nurseries.

Services and supplies provided by a Hospital for emergency care and treatment for a medical emergency, including the sudden onset or worsening of a medical condition that manifests itself by

symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent lay person, who possesses an average knowledge of health and medicine to result in:

- Placing the patient's health in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dsyfunction of any bodily organ or part.

Coverage is also provided for the cost of a voluntary HIV screening test performed while receiving emergency care in a Hospital, once per calendar year, regardless of whether or not the HIV screening is necessary for the treatment of the condition for which the emergency care is sought.

Infertility Treatment

Diagnosis and treatment of infertility, including surgery and drug therapy. This does not include procedures or services to facilitate a pregnancy, such as, but not limited to, in vitro fertilization, embryo transfer, artificial insemination and immunotherapy for infertility.

Medical Supplies

- Surgical supplies (such as bandages and dressings). Supplies given during surgery or a diagnostic procedure are included in the overall cost for that surgery or diagnostic procedure.
- Blood or blood plasma only if not donated or replaced.

Nursing Services

Services of a trained nurse or a Nurse-Midwife.

Occupational Therapy

Services of a licensed occupational therapist provided the following conditions are met:

- The therapy must be ordered and monitored by a Physician.
- The therapy must be given in accordance with a written treatment plan approved by a Physician. The therapist must submit progress reports to the Physician at the intervals stated in the treatment plan.
- The therapy must be expected to result in significant, objective, measurable physical improvement within 2 months of the start of treatment.

Organ/Tissue Transplants

- Donor Charges

  In the case of an organ or tissue transplant, no services or supplies for the donor are considered Covered Health Services unless the recipient is the Employee or his/her Dependent. If the recipient is not the Employee or his/her Dependent, no benefits are payable for donor charges.

  The search for bone marrow/stem cell from a donor who is not biologically related to the patient is not considered a Covered Health Service UNLESS the search is made in connection with a transplant procedure arranged by a Transplant Facility.

- Qualified Procedures

  If a qualified procedure, listed below, is Medically Appropriate, the "Medical Care and Treatment" provisions set forth below apply:

  - Heart transplants

- Heart/lung transplants
- Liver transplants
- Kidney transplants
- Pancreas transplants
- Kidney/pancreas transplants
- Bone marrow/stem cell transplants
- Other transplant procedures when UnitedHealthcare determines that it is necessary to perform the procedure at a Treatment Facility.

- Medical Care and Treatment
  - The following services provided in connection with the transplant are Covered Health Services:
    - Pre-transplant evaluation for one of the procedures listed above
    - Organ acquisition and procurement
    - Hospital and Physician fees
    - Transplant procedures
    - Follow-up care for a period up to one year after the transplant
    - Search for bone marrow/stem cell from a donor who is not biologically related to the patient. If a separate charge is made for a bone marrow/stem cell search, a maximum benefit of $25,000 is payable for all charges made in connection with the search.

- Transportation and Lodging

  The following benefits for transportation and lodging expenses are available for those Medically Appropriate Qualified Procedures, as listed above, that are performed at a Transplant Facility. If a Transplant Facility is not used, then these transportation and lodging benefits will not be covered.

  Care Coordination will assist the patient and family with travel and lodging arrangements. Expenses for travel, lodging and meals for the transplant recipient and a companion are available under this Plan as follows:

  - Reasonable and necessary expenses for transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of the transplant for the purposes of an evaluation, the transplant procedure or necessary post-discharge follow-up.
  - Reasonable and necessary expenses for lodging and meals for the patient (while not confined) and one companion. Benefits are paid at a per diem rate of up to $50 for one person or up to $100 for two people.

  Travel and lodging expenses are only available if the transplant recipient resides more than 50 miles from the Transplant Facility.

  If the Dependent who is the patient is a minor child, the transportation expenses of two companions will be covered and lodging and meal expenses will be reimbursed up to the $100 per diem rate.

  There is a combined overall lifetime maximum of $10,000 per Employee or Dependent for all transportation, lodging and meal expenses incurred by the transplant recipient and companion(s) and reimbursed under this Plan P [and Plans A, B and/or C, combined], in connection with all transplant procedures.

Outpatient Alcoholism, Chemical Dependency and Mental Illness Services

Benefits for outpatient services to treat alcoholism, chemical dependency and/or mental illness. The Plan pays 75% of the Covered Expenses in a calendar year after the Deductible is satisfied for the first 40 outpatient visits for alcoholism, chemical dependency and/or mental illness, and then 60% of any additional visits.

Physical Therapy

Services of a licensed physical therapist, provided the following conditions are met:

- The therapy must be ordered and monitored by a Physician.
- The therapy must be given in accordance with a written treatment plan approved by a Physician.
- The therapist must submit progress reports to the Physician at the intervals stated in the treatment plan.

The therapy must be expected to result in significant, objective, measurable physical improvement within two months of the start of the treatment.

Physicians Services

Prescription Drugs

Prescription drugs other than those obtained from a retail pharmacy or by mail order.

Prescription Contraceptive Devices

Devices approved by the U.S. Food and Drug Administration for the prevention of a pregnancy are covered for female employees and the wives of male employees.

Preventive Adult Health Services

- Benefits are available for mammography testing that is consistent with the recommendations of governmental scientific agencies. Benefits for mammography testing are payable when mammography testing is performed as follows:
    - a baseline mammogram; and
    - follow-up mammograms on an annual basis.
- Pap smears are covered annually, or when it is determined by the attending physician that the test is necessary.

The preventive services listed above are not subject to coinsurance or the calendar year Deductible.

- Colorectal cancer screenings are covered in compliance with the American Cancer Society colorectal cancer screenings guidelines.
- Screenings in accordance with the latest screening guidelines issued by the American Cancer Society.

Preventive Child Health Services

Benefits are available from birth to age 21 including:

- Coverage for injury or sickness, including the necessary care and treatment of medically diagnosed congenital defects, birth abnormalities, and prematurity; and
- Coverage for preventive and primary care services, including physician examinations, measurements, sensory screening, neuropsychiatric evaluation, and development screening, which coverage shall include unlimited visits up to the age of 12 years, and 3 visits per year for minor children ages 12 years up to age 21 years of age. Preventive and primary care services shall also include, as recommended by the physician, hereditary and metabolic screening at birth, immunizations, urinalysis, tuberculin tests, and hematocrit, hemoglobin, and other appropriate blood tests, including tests to screen for sickle hemoglobinopathy.

Psychologist Services

Radiation Therapy

Rehabilitative Services

Benefits for occupational therapy, speech therapy and physical therapy for Dependent children, under the age of 21, with congenital or birth defects (including autism and cerebral palsy).

Skilled Nursing Facility Care After Hospital Confinement

Services and supplies up to 31 days of confinement following each Hospital confinement.

Separate confinements for the same cause are considered to be one confinement, unless separated by 14 or more days.

If charges are made for a private room, Covered Expenses will be limited to the facility's daily charge for a semi-private room.

Speech Therapy

These services must be given to restore speech. The speech must have been lost or impaired due to one of the following:

- Removal of vocal cords.
- Cerebral thrombosis (cerebral vascular accident).
- Brain damage due to injury or organic brain lesion (aphasia).

The therapy must be expected to result in significant, objective, measurable physical improvement within two months of the start of the treatment.

Spinal Manipulations

Services of a physician given for the detection or correction (manipulation) by manual or mechanical means of structural imbalance or distortion in the spine.

No benefits are available for any type of therapy, service or supply, including, but not limited to, spinal manipulation by a chiropractor or other phsycian once the therapy, service or supply ceases to be therapeutic and is instead administered to maintain a level of functioning or to prevent a medical problem from occuring or reoccurring.

Telehealth

Charges for services provided through telehealth rather than face-to-face consultation when the services can appropriately be provided through telehealth.

- "Telehealth" means the use of live, interactive audio and visual transmissions of a physician-patient encounter from one site to another using telecommunications technologies. They may include transmissions of real-time telecommunications or those transmitted by store-and-forward technology.

- Telemedicine services are medical services provided via interactive audio, video or other electronic media for the purpose of diagnosis, consultation, or treatment that do not involve direct, in-person patient contact.

Transportation Services

Transportation charges are covered for transportation to a Hospital in an emergency.

The transportation services must be to a Hospital in your local area. If there are no local Hospitals that can provide the care needed, charges for transportation to the nearest Hospital outside your local area qualified to give the required treatment, will be covered.

Treatment Center Services

Charges for services at a Treatment Center when a Physician or Psychologist has certified an alcoholism or chemical dependency and has prescribed such services, up to a calendar year maximum of 60 days. In addition, detoxification services will be covered for up to 12 days annually.

X-ray and Laboratory Tests

EXCLUSIONS

Major Medical Expenses Benefits are not payable for expenses for:

- Expenses for any confinement, treatment, services or supplies which would have been payable under the Amtrak Early Retirement Plan or the TransitAmerica Services, Inc. Early Retirement Plan, but which were not payable due to you or your Dependent's non-compliance with any required medical management provisions described under the Amtrak Early Retirement Plan or the TransitAmerica Services, Inc. Early Retirement Plan.
- Prescription Drugs purchased from a pharmacy or by mail order.
-

Other exclusions that apply to this Benefit are in the General Exclusions section.

IX

GENERAL EXCLUSIONS

This Plan does not cover any expenses incurred for services, supplies, medical care or treatment relating to, arising out of, or given in connection with the following, even if recommended or prescribed by a Physician or is the only treatment available for your condition:

- Dependent who is covered as an Employee for the same services under this Plan.
- A Dependent who is covered as an Employee under any Hospital Association Plan.
- Dependent child's pregnancy or the resulting childbirth, adoption or miscarriage.
- Dependents' Work Related Injury or Sickness - services or supplies for which your Eligible Dependent is entitled to indemnity under any workers' compensation or similar law.
- Service or supplies received before an Employee or his or her Dependent becomes covered under the Plan.
- Abdominoplastys (unless covered under GA-46000, the Amtrak Early Retirement Plan, the Keolis Commuter Services (formerly MBCR) Early Retirement Plan, or the TransitAmerica Services, Inc. (TASI) Early Retirement Plan).
- [Alternative Treatments, such as acupressure, aromatherapy, hypnotism, massage therapy, rolfing, and art therapy, music therapy, dance therapy, horseback therapy and other forms of alternative treatment as defined by the *National Center for Complementary and Alternative Medicine (NCCAM)* of the *National Institutes of Health.]*
- Breast reduction surgery (unless covered under GA-46000, the Amtrak Early Retirement Plan, the Keolis Commuter Services (formerly MBCR) Early Retirement Plan, the TransitAmerica Services, Inc. (TASI) Early Retirement Plan, or Medicare).
- Chelation therapy, except to treat heavy metal poisoning.
- Completion of claim forms, or missed appointments.
- Cosmetic/Reconstructive Surgery - Cosmetic or reconstructive surgery or treatment, whether or not it is for psychological or emotional reasons, except for reconstructive surgery to improve the function of a body part when the malfunction is a direct result of one of the following:
    - Birth defect
    - Sickness
    - Injury which occurs while the individual is covered under this policy
    - Surgery

    The following reconstructive surgery is also covered:

    - Reconstructive breast surgery following a mastectomy, including surgery on the non-affected breast to achieve symmetry. Additional services include breast prosthesis and treatment of physical complications during all stages of the mastectomy including lymphedemas.
    - Reconstructive surgery to remove scar tissue on the neck, face or head if the scar tissue is due to injury which occurs or a sickness which commences while the individual is covered under this policy.

- Court Ordered Treatment - Examinations or treatment ordered by a court in connection with legal proceedings except as specifically provided under this policy.
- Coverage Under Other Railroad Health Plans - any confinement, treatment, services or supplies if benefits are payable for these expenses under any other employer group health plan as an Employee. Any premium payments made under this policy for any month that coverage is provided under any other employer group health plan will be refunded upon your request. Contact UnitedHealthcare for assistance.
- Custodial Care (see Definitions), except as specifically covered under Plan F.
- Drugs, including the following:
    - Prescription drug products for outpatient use that are filled by a prescription order or refill.
    - Self-injectable medications. This exclusion does not apply to medications which, due to their characteristics (as determined by UnitedHealthcare), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting.
    - Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectiable medications that are required in an Emergency and consumed in the Physician's office.
    - Over-the-counter drugs and treatments.
    - Growth hormone therapy (unless covered under GA-46000, the Amtrak Early Retirement Plan, the Keolis Commuter Services (formerly MBCR) Early Retirement Plan, the TransitAmerica Services, Inc. (TASI) Early Retirement Plan, or Medicare).
- Durable Medical Equipment does not include any of the following items:
    - Non-hospital beds, comfort beds, motorized beds/mattresses.
    - Devices and computers to assist in communication and speech except for speech aid prosthetics and traceo-esophaeal voice prosthetics.
    - Wigs in excess of [$500 per calendar year] and/or for reasons other than loss of hair resulting from treatment of a malignancy or permanent loss of hair from an accidental injury.
    - Dental braces.
    - Braces that straighten or change the shape of a body part, except those braces that stabilize an injured body part and braces to treat curvature of the spine.
    - Air-conditioners, humidifiers, dehumidifiers, air purifiers and filters, and personal comfort items.
    - Durable Medical Equipment provided to you by a Physician.
    - Generally, any device, appliance, pump, machine stimulator, or monitor that is fully implanted into the body.
- Ecological or environmental medicine, diagnosis and/or treatment.
- Education, training and bed and board while confined in an institution which is mainly a school or other institution for training, a place of rest, a place for the aged or a nursing home.
- Eye examinations, glasses or contact lenses for diagnosis or treatment of refractive errors except to the extent needed for repair of damages caused by bodily injury sustained while covered (unless covered under GA-46000, the Amtrak Early Retirement Plan, the Keolis Commuter Services (formerly MBCR) Early Retirement Plan, the TransitAmerica Services, Inc. (TASI) Early Retirement Plan or Medicare).
- Ear examinations, hearing aids or cochlear implants for diagnosis or treatment of hearing loss except due to the extent needed for repair of damages caused by bodily injury sustained while covered (unless covered under GA-46000, the Amtrak Early Retirement Plan, the Keolis Commuter Services

(formerly MBCR) Early Retirement Plan, the TransitAmerica Services, Inc. (TASI) Early Retirement Plan or Medicare).

- Experimental or Investigational or Unproven Services and all services related to Experimental or Investigational and Unproven Services are excluded. The fact that an Experimental or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particual condition.
- Herbal medicine, holistic or homeopathic care, including drugs.
- Services, supplies medical care or treatment given by one of the following members of the Employee's immediate family:
  - The Employee's spouse.
  - The child, brother, sister, parent or grandparent of either the Employee or the Employe's spouse.
- Charges for procedures which facilitate a pregnancy but do not treat the cause of infertility, such as in vitro fertilization, artificial insemination, embryo transfer, gamete intrafallopian transfer, zygote intrafallopian transfer and tubal ovum transfer.
- Medical, surgical, diagnostic, psychiatric, substance abuse or other health care services, technologies, supplies, treatments, procedures, drug therapies or devices that, at the time UnitedHealthcare Insurance Company makes a determination regarding coverage in a particular case are determined to be:
  - not approved by the U.S. Food an Drug Administration ("FDA") to be lawfully marketed for the proposed use and not identified in the American Formulary Service, or the United States Pharmacopoeia Dispensing Information, as appropriate for the proposed use; or
  - subject to review and approval by any institutional review board for the proposed use; or
  - the subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight; or
  - a service that does not meet the definition of a Covered Health Service.

  If a Covered Person has a "life-threatening" Sickness or condition (one which is likely to cause death within one year of the request for treatment), UnitedHealthcare may determine that an Experimental, Investigational or Unproven Service meets the definition of a Covered Health Service for the Sickness or condition. For this to take place, UnitedHealthcare must determine that the service uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.
- Services and supplies which the Covered Person is not legally required to pay.
- Liposuction.
- Surgical correction or other treatment of a malocclusion.
- Services and supplies which are not Covered Health Services, including any confinement or treatment given in connection with a service or supply which is not covered under the Plan.
- Membership costs for health clubs, weight loss clinics and similar programs.
- Nutritional counseling except if provided for diabetes self-management training.
- Services given by a pastoral counselor.

- Personal convenience items, including but not limited to such items as TV's, telephones, first aid kits, exercise equipment, air conditioners, humidifiers, saunas and hot tubs.
- Private duty nursing services.
- Routine foot care, including but not limited to, nail cutting and trimming and removal of corns and calluses, except when required for the prevention of complications due to diabetes or severe systemic disease.
- Services for a surgical procedure to correct refractive errors of the eye, including any confinement, treatment, services or supplies given in connection with or related to the surgery.
- Sterilization procedures, except to avoid a life-threatening condition.
- Reversal of sterilization.
- Rhytidectomy.
- Sensitivity training, educational training therapy or treatment for an education requirement.
- Charges made by a Hospital for a confinement in a special area of the Hospital which provides non-acute care, by whatever name called, including but not limited to the type of care given by the facilities listed below. If that type of facility is otherwise covered under this Plan, then benefits for that covered facility which is part of a Hospital, as defined, are payable at the coverage level for that facility, not at the coverage level for a Hospital.
    - Adult or child day care center.
    - Ambulatory Surgical Center.
    - Birth Center.
    - Half-way house.
    - Hospice.
    - Skilled Nursing Facility.
    - Treatment Center.
    - Vocational rehabilitation center.
    - Any other area of a Hospital which renders services on an inpatient basis for other than acute care of sick, injured or pregnant persons.
- Stand-by services required by a Physician.
- Dental Services - care of and treatment to the teeth and gums except for the following:
    - Hospital, radiology and pathology services while confined as an in- patient in a Hospital for dental surgery or within 72 hours of dental surgery, and
    - Full or partial dentures, fixed bridgework, or repair to natural teeth if needed because of accidental injury to natural teeth which happens while covered.
- Dental Implants
- Treatment or consultations provided via audio only telephone, email messages or fax transmissions.
- Transplant services that are not performed at a Transplant Facility. This exclusion applies to Plans A, B and C only.

- Tobacco dependency.
- Services or supplies received as a result of war declared or undeclared, or international armed conflict.
- Weight reduction or control (unless there is a diagnosis of morbid obesity).
- Special foods, food supplements, liquid diets, diet plans or any related products.
- Wigs or toupees (except for loss of hair resulting from treatment of a malignancy or permanent loss of hair from an accidental injury costing under [$500 per calendar year]), hair transplants, hair weaving or any drug if such drug is used in connection with baldness.
- Services given by volunteers or person who do not normally charge for their services.
- Donor Expenses - expenses incurred by an organ donor, except as specifically provided under this Policy.
- Government Hospital –
    - for any confinement in a United States government or agency hospital. However, the reasonable cost incurred by the United States or one of its agencies for in-patient or out-patient medical care and treatment given by a military hospital may be covered under the Plan. This coverage applies only to care and treatment provided to:
        - A person retired from the uniformed services,
        - a family member of a person who is retired from the uniformed services,
        - a family member of a person who is active in the uniformed services, or
        - a family member of a deceased member of the uniformed services.
- Educational rehabilitation, or treatment of learning disabilities, regardless of the setting in which such services are provided.
- Treatment for personal or professional growth, development, or training or professional certification.
- Evaluation, consultation, or therapy for educational or professional training or for investigational purposes relating to employment.
- Examinations, testing, evaluations or treatment which may be required solely for purposes of obtaining or maintaining employment or insurance, pursuant to judicial order or administrative proceedings, or as may be required to participate in sports or attend school, to travel, or for the purposes of marriage or adoption.
- Academic education during residential treatment.
- Therapies such as Erhard/The Forum, primal therapy, aversion therapy, bioenergetic therapy, crystal healing therapy.
- Counseling services and/or treatment related to such problems as financial, marital or occupational difficulties, adult anti-social behavior or parent-child relationships.
- Non-abstinence based or nutritionally based chemical dependency treatment.

If a person is covered under this policy as a dependent of two Employees, benefits payable under this policy will be limited to the benefits for which only one of the Employees is entitled to on account of the expenses incurred in connection with the Dependent.

In no event will benefits under Plans A, B, C, E, M, or P be payable for any expenses incurred by any person on or after the date he or she becomes a Person Eligible Under Medicare.

Expenses incurred for services and supplies that the policy would not normally cover will be considered for payment of benefits if they are part of an "Alternate Care Plan (ACP)" that has been developed by UnitedHealthcare and agreed to by you or your dependent as a substitute for services and supplies that you or your Dependent are eligible for under the policy. Benefits for services and supplies provided under the Alternate Care Plan are subject to and count towards the policy's provisions regarding benefit amounts, maximum benefits, copayments and deductibles that apply to the services and supplies for which they are in substitution.

[X
BENEFITS AFTER COVERAGE ENDS

Plans A, B and C

If you or your Dependent is disabled on the date your coverage ends, Major Medical Expense Benefits apply to expenses incurred in the calendar year in which your coverage ends and the next succeeding calendar year, but only for the bodily injury or sickness causing continuous disability of you or your Dependent from the date your coverage ends, except that benefits are not payable on or after the date the disabled person becomes a Person Eligible Under Medicare.

Maternity benefits apply to expenses incurred after coverage ends in connection with a pregnancy which commenced while you or your Dependent wife was covered. The disability requirements stated above do not apply.

The Treatment Center Services benefits apply to confinements that began while you were covered.

Plan F

Treatment Center Expense Benefits apply to confinements that began while you were covered.

All other benefits are not provided under Plan F for expenses incurred after coverage ends.

Plans E, M and P

If you or your Dependent is disabled on the date your coverage ends Major Medical Expense Benefits will continue to apply subject to the following conditions: Benefits are payable only for expenses incurred with respect to your or your Dependent's bodily injury or sickness causing the disability.

The disability must be continuous from the date coverage ends to the date each expense is incurred.

Benefits are payable for the calendar year in which coverage ends and during the next calendar year.

Benefits are not payable for expenses incurred by any person on or after the date he or she becomes a Person Eligible Under Medicare.

Treatment Center Expense Benefits apply to confinements that began while you were covered.]

[XI]
DEFINITIONS

Alternate Care Plan

A plan of alternate utilization of medical services which includes cost-effective appropriate care alternatives to services which are otherwise covered by the policy. The alternate medical services may not be otherwise covered by the policy.

Ambulatory Surgical Center

A specialized facility which fully meets all the tests set forth in (1) or (2) below:

(1) Has been licensed as an ambulatory surgical center in accordance with the applicable laws in the jurisdiction in which it is located by the state's regulatory authority, as being established, equipped, operated and staffed primarily for the purpose of performing surgical procedures; or

(2) Where state licensing is not required, meets all of the following requirements:

- It is established, equipped and staffed primarily for the purpose of performing surgical procedures.
- It is operated under the supervision of a licensed doctor of medicine (M.D.) or doctor of osteopathy (D.O.) who is devoting full time to such supervision and permits a surgical procedure to be performed only by a duly qualified physician who, at the time the procedure is performed, is privileged to perform such procedure in at least one hospital in the area.
- It requires in all cases other than those requiring only local infiltration anesthetics, that a licensed anesthesiologist administer the anesthetic or supervise an anesthetist who is administering the anesthetic and that the anesthesiologist or anesthetist remain present throughout the surgical procedure.
- It provides at least one operating room and at least one post- anesthesia recovery room.
- It is equipped to perform diagnostic X-ray and laboratory examinations or has an arrangement to obtain such, as necessary.
- It has trained personnel and necessary equipment to handle emergency situations.
- It has immediate access to a blood bank or blood supplies, if necessary.
- It provides the full-time services of one or more registered graduate nurses (R.N.) for patient care in the operating room and in the post-anesthesia recovery room.
- It maintains an adequate medical record for each patient, such record to contain an admitting diagnosis including, for all patients except those undergoing a procedure under local anesthesia, a preoperative examination report, medical history and laboratory tests and/or X-rays, an operative report and a discharge summary.

Amtrak Early Retirement Plan

The Amtrak Union Retiree Benefit Plan.

Assistant Surgeon Services

Where necessary, the services of an assistant surgeon are limited to one-fifth of the amount of Covered Expenses for the surgeon's charge for the surgery.

Birth Center

A specialized facility which is primarily a place for delivery of children following a normal uncomplicated pregnancy and which fully meets one of the following two tests:

- It is licensed by the regulatory authority having responsibility for such licensing under the laws of the jurisdiction in which the facility is located.
- Where licensing is not required, it meets all of the following requirements:
    - It is operated and equipped in accordance with any applicable state law.
    - It is equipped to perform routine diagnostic and laboratory examinations.
    - It has trained personnel and necessary equipment available to handle foreseeable Emergencies.
    - It is operated under the full-time supervision of a doctor of medicine (M.D.) or registered nurse (R.N.)
    - It maintains a written agreement with at least one Hospital in the area for immediate acceptance of patients who develop complications.
    - It is expected to discharge or transfer patients within 24 hours following delivery.

Chemotherapy

The treatment of malignant conditions using antineoplastic agents which are administered:

- at a controlled rate through a catheter placed surgically in an artery,
- intramuscularly,
- subcutaneously, or
- orally.

Antineoplastic agents are those chemotherapy drugs which have been accepted for inclusion in the U.S. Pharmacopoeia, National Formulary, or have been accepted by the Federal Drug Administration and/or have received official approval by the American Medical Association Council on Drugs.

COBRA

Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Convenient Care Clinic

A health care facility typically located in a high-traffic retail store, supermarket or pharmacy that provides affordable treatment for uncomplicated minor illness and/or preventive care to consumers. Please contact Member Services (phone number located on the back of your Member Indentifcation Card) to locate a Convenient Care Clinic.

Covered Health Service(s)

Covered Health Services are those health services, supplies or equipment provided for the purpose of preventing, diagnosing or treating a Sickness, Injury, Mental Illness, substance abuse, or symptoms. Covered Health Services must be provided:

- When the Plan is in effect;
- Prior to the date that any of the individual termination conditions set forth in this Certificate of Coverage; and
- Only when the person who receives services is a Covered Person and meets all eligibility requirements specified in the Plan.

A Covered Health Service must meet each of the following criteria:

- It is supported by national medical standards of practice.
- It is consistent with conclusions of prevailing medical research that demonstrates that the health service has a beneficial effect on health outcomes and are based on trials that meet the following designs:
    - Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)
    - Well-conducted cohort studies. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)
- It is the most cost-effective method and yields a similar outcome to other available alternatives.
- It is a health service or supply that is described in this Certificate, and which is not excluded under General Exclusions.

Decisions about whether to cover new technologies, procedures and treatments will be consistent with conclusions of prevailing medical research, based on well-conducted randomized trials or cohort studies, as described.

Custodial Care

Care made up of services and supplies that meets one of the following conditions:

- Care furnished mainly to train or assist in personal hygiene or other activities of daily living, rather than to provide medical treatment.
- Care that can safely and adequately be provided by persons who do not have the technical skills of a covered health care professional.
- Care that meets one of the conditions above is custodial care regardless of any of the following:

- Who recommends, provides or directs the care.
- Where the care is provided.
- Whether or not the patient can be or is being trained to care for himself or herself.

Dependent

With respect to Plans A, B, C, E, and F

- The Employee's spouse,
- The Employee's unmarried children from birth through age 18,
- The Employee's unmarried children 19 years of age but under 25 years of age, who have their legal residence with the Employee, and who are wholly dependent upon the Employee for maintenance and support and who are registered Students in regular, full-time attendance at an accredited secondary school, college or university or institution for the training of nurses, and
- The Employee's unmarried children 19 years of age or over who have their legal residence with the Employee and who are wholly dependent upon the Employee for maintenance and support and who have a permanent physical or mental condition which is such that they are unable to engage in any regular employment, provided that such disability began prior to the child attaining 19 years of age.

Please note, in order to continue Dependent coverage past age 19, you must contact UnitedHealthcare and notify us of your Dependent's Student status or disability. In addition, proof of Student status or disability may be required.

[With respect to Plan M

- Any dependent of the Employee that is covered under the Keolis Commuter Services (formerly MBCR) Early Retirement Plan.

With respect to Plan P

- Any dependent of the Employee that is covered under the Amtrak Early Retirement Plan or the TransitAmerica Services, Inc. (TASI) Early Retirement Plan.]

Durable Medical Equipment – medical equipment that is all of the following:

- Can withstand repeated use.
- Is not disposable.
- Is used to serve a medical purpose with respect to treatment of a sickness, injury or their symptoms.
- Is generally not useful to a person in the absence of a sickness, injury or their symptoms.
- Is appropriate for use, and is primarily used, within the home.
- Generally, is not implantable within the body.

Employee

A U.S. resident who is classified as one of the following:

- a currently inactive railway employee who was covered as an active employee under one of the following plans:
  - Railroad Employees National Health and Welfare Plan .
  - [NRC/UTU Plan].
  - Any other health and welfare plan established pursuant to an agreement between one or more railroads and one or more labor organizations.
- A currently retired or disabled railway industry employee who is covered under The Railroad Employees National Early Retirement Major Medical Benefit Plan (GA-46000) or any other group health plan deemed by UnitedHealthcare to provide benefits identical to those provided under GA-46000.
- A currently retired or disabled railway industry employee who is covered under the Keolis Commuter Services (formerly MBCR) Early Retirement Plan or any other group health plan deemed by UnitedHealthcare to provide benefits identical to those provided under the Keolis Commuter Services (formerly MBCR) Early Retirement Plan.
- A currently retired or disabled railway industry employee who is covered under the Amtrak Early Retirement Plan or the TransitAmerica Services, Inc. (TASI) Early Retirement Plan or any other group health plan deemed by UnitedHealthcare to provide benefits identical to those provided under the Amtrak Early Retirement Plan.
- A currently inactive Cooperating Railway Labor Organization employee who was covered as an active employee under the Railway Labor Organizations Group Life and Hospital, Surgical and Medical Benefit Plan for Their Officers and Employees (GA-107300).
- With respect to coverage for parents and parents-in-law under Plan F, an active or Inactive Employee covered under GA-23111, Railroad Employees National Health and Welfare Plan, [NRC/UTU Plan], GA-46000, the Amtrak Early Retirement Plan, the Keolis Commuter Services (formerly MBCR) Early Retirement Plan, the TransitAmerica Services, Inc. Early Retirement Plan or GA-107300.

Experimental or Investigational or Unproven Service(s)

Medical, surgical, diagnostic, psychiatric, substance abuse or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time UnitedHealthcare makes a determination regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the *U.S. Food and Drug Administration* (FDA) to be lawfully marketed for the proposed use and not identified in the *American Hospital Formulary Service* or the *United States Pharmacopoeia Dispensing Information* as appropriate for the proposed use.
- Subject to review and approval by an institutional review board for the proposed use (Devices which are FDA approved under the *Humanitarian Use Device* exemption are not considered to be Experimental or Investigational.)
- The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical test set forth in the FDA regulations, regardless of whether the trial is actully subject to FDA oversight.

Exceptions:

- Life-Threatening Sickness or Condition. If you have a life-threatening sickness or condition (one that is likely to cause death within one year of the request for treatment) UnitedHealthcare may, at its discretion, consider an otherwise Experimental or Investigational or Unproven Service to be a Covered Health Services for that sickness or condition. Prior to such a consideration, UnitedHealthcare must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that sickness or condition, and that the service would be provided under standards equivalent to those defined by the *National Institutes of Health*.

Full Medicare Coverage

Coverage for all the benefits provided under both Medicare Part A and Medicare Part B. For the purpose of coverage under this policy, each Person Eligible Under Medicare shall be deemed to have Full Medicare Coverage.

Full Medicare Coverage will include any benefit which could have been provided under Medicare, but which are not provided under Medicare for any of the following reasons:

- The person is not enrolled in Medicare.
- The person is enrolled in a Medicare Advantage Plan.
- The person receives services from a provider who has elected to opt-out of Medicare.
- The person is enrolled under a plan with a Medicare Savings Account.
- Medicare benefits are reduced because of any benefits paid in accordance with:
  - any plan of insurance regulated by or through action of any automobile reparations act of any government,
  - any policy or plan which includes automobile medical payments benefits,
  - the provisions of any liability insurance policy or plan, or
  - the availability of health coverage under a group health plan which must pay benefits primary to Medicare.

Furloughed Employee

The term "Furloughed Employee" as used herein means an Employee furloughed or placed on leave of absence while covered for Employee or Dependents benefits under the Railroad Employees National Health and Welfare Plan, [NRC/UTU Plan], GA-107300 [,GA-46000, Amtrak Early Retirement Plan, Keolis Commuter Services (formerly MBCR) Early Retirement Plan or TransitAmerica Services, Inc. (TASI) Early Retirement Plan]. The term Furloughed Employee shall also include:

- any individual whose coverage under the Railroad Employees National Health and Welfare Plan or [NRC/ UTU Plan] is terminated but whose status is being considered in proceedings under the Railway Labor Act, as certified by the Policyholder; and
- any Employee on furlough or leave of absence who was covered as a Furloughed Employee under the Former Policy; and
- any individual whose insurance under the Railroad Employees National Health and Welfare Plan or [NRC/ UTU Plan] is terminated following the termination of his or her employment relationship by a reason of his or her change in the Employer's practices or method of operation, such as a merger, consolidation or abolition of the individual's position, but in no event beyond date such individual becomes covered under a health and welfare plan.

Wherever reference is made herein to employment, furlough or being placed on a leave of absence, it shall mean employment, furlough or being placed on leave of absence by the Employer included under the Railroad Employees National Health and Welfare Plan or [NRC/UTU Plan] or GA-107300 by whom the Employee was last employed prior to the termination of his or her coverage under such plans.

In no event shall the term Furloughed Employee include any individual beyond the termination of any such furlough or leave.

GA-107300

Railway Labor Organizations Group Life Insurance and Hospital, Surgical and Medical Benefit Plan for Their Officers and Employees. Any reference to any other employer group health plan is a reference to GA-107300.

GA-46000

The Railroad Employees National Early Retirement Major Medical Benefit Plan and any other group health plan which is determined by UnitedHealthcare to provide benefits identical to the Railroad Employees National Early Retirement Major Medical Benefit Plan.

Home Health Care Agency

An agency or organization which provides a program of home health care and which fully meets one of the following three tests.

- It is approved under Medicare.
- It is established and operated in accordance with the applicable licensing and other laws.
  - It meets all of the following tests:
  - It has the primary purpose of providing a home health care delivery system bringing supportive services to the home.
  - It has a full-time administrator.
  - It maintains written records of services provided to the patient.
  - Its staff includes at least one registered graduate nurse (R.N.) or it has nursing care by a registered graduate nurse (R.N.) available.
  - Its employees are bonded and it provides malpractice and malplacement insurance.

Hospice

An agency that provides counseling and incidental medical services for a terminally ill individual. The agency must meet all of the following tests:

- It is approved under any required state or governmental Certificate of Need.
- It provides 24 hour-a-day, 7 day-a-week service.
- It is under the direct supervision of a physician.
- It has a social-service coordinator who is licensed in the area in which it is located.
- The main purpose of the agency is to provide Hospice services.
- It has a full-time administrator.
- It is established and operated in accordance with any applicable state laws.

A part of a Hospital that meets the criteria set forth above will be considered as a Hospice for the purpose of this policy.

Hospital

An institution which is engaged primarily in providing medical care and treatment of sick and injured persons on an in-patient basis at the patient's expense and which fully meets all the tests set forth in (a) or (b) or (c) below:

(a) It is a hospital accredited by the Joint Commission on Accreditation of Health Care Organizations.

(b) It is a hospital or a psychiatric hospital, as those terms are defined in Medicare, which is qualified to participate and eligible to receive payments under and in accordance with the provisions of Medicare.

(c) It is an institution which fully meets all of the following tests:

- It maintains on the premises diagnostic and therapeutic facilities for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of duly qualified physicians; and
- It continuously provides on the premises twenty-four hour a day nursing service by or under the supervision of registered graduate nurses; and
- It is operated continuously with organized facilities for operative surgery on the premises.

Inactive Employee

Former railroad or union employees who were covered as active employees under the Railroad Employees National Health and Welfare Plan, [NRC/UTU Plan], GA-107300, [GA-46000, Amtrak Early Retirement Plan, Keolis Commuter Services (formerly MBCR) Early Retirement Plan or TransitAmerica Services, Inc. (TASI) Early Retirement Plan] who were terminated from active employment for one of the following reasons:

- Furlough as defined above under Furloughed Employee.
- Suspension or dismissal.
- Retirement.
- Termination of employment relationship for reasons other than retirement or dismissal.
- Disability.

Keolis Commuter Services (formerly MBCR) Early Retirement Plan

Level of Care

The duration, frequency, location, intensity and/or magnitude of a treatment setting, treatment plan, or treatment modality, including, but not limited to:

- acute care facilities;
- less intensive inpatient or outpatient alternatives to acute care facilities such as residential treatment centers, group homes or structured outpatient programs;
- outpatient visits; or
- medication management.

Medical Judgment

Judgment with respect to any of the following issues in connection with a claim for benefits:

- medical necessity;
- appropriateness of care;
- health care setting;
- level of care;
- effectiveness of a covered benefit; or
- a determination of whether a treatment or a procedure is experimental or investigational.

Medically Appropriate

A Covered Health Service which has been determined by UnitedHealthcare to be the appropriate Level of Care that can safely be provided for the specific covered individual's diagnosed condition in accordance with the professional and technical standards adopted by UnitedHealthcare .

Medicare

The Health Insurance for The Aged and Disabled program under Title XVIII of The Social Security Act as such Act was amended by the Social Security Amendments of 1965 (Public Law 89-97), 1967 (Public Law 90-248) and 1972 (Public Law 92-603), as such program is currently constituted and as it may be later amended.

Multiple Surgical Procedures

Multiple surgical procedures means more than one surgical procedure performed during the same operative session. Covered Expenses for multiple surgical procedures are limited as follows:

- Covered Expenses for a secondary procedure are limited to 50% of the Covered Expenses that would otherwise be considered for the secondary procedure had it been performed during a separate operative session.
- Covered Expenses for any subsequent procedure are limited to 50% of the Covered Expenses that would otherwise be considered for the subsequent procedure had it been performed during a separate operative session.

Nurse-Midwife

A person who is certified to practie as a Nurse-Midwife and who:

- Is licensed as a registered nurse by the appropriate board of nursing having responsibility for such licensure under the laws of the jurisdiction where such person renders services, and
- Has completed a program for the training of Nurse-Midwives approved by the appropriate regulatory authority having responsibility for such programs under the laws of the jurisdiction where such program is provided.

[NRC/UTU Plan

National Railway Carriers and United Transportation Union Health & Welfare Plan.]

Person Eligible Under Medicare

An Employee or Dependent who is enrolled under Medicare Parts A and B or has been eligible to enroll under Medicare Parts A and B.

Under Plan E, if the basis for Medicare coverage is end stage renal disease, an Employee or Dependent shall not be a Person Eligible Under Medicare until the end of a 30 month period beginning with the first day of the person's Medicare eligibility.

Physician

A legally qualified:

- Doctor of Medicine (M.D.)
- Doctor of Chiropody (D.S.C.)
- Doctor of Chiropractic (D.C.)
- Doctor of Dental Surgery (D.D.S.)
- Doctor of Medical Dentistry (D.M.D.)
- Doctor of Optometry (O.D.)
- Doctor of Osteopathy (D.O.)
- Doctor of Podiatry (D.P.M.)
- [Provider, other than those listed above, who is properly licensed in the state in which he or she is practicing, that delivers services that may also be delivered by a medical doctor.]
- Physician's Assistant when operating under the direction of one of the above Physicians.

Policy

The entire agreement issued to the Policyholder, that includes the following:

- the Group Policy
- this Certificate of Coverage
- Amendments
- Riders

These documents make up the entire agreement that is issued to the Policyholder.

Policyholder

The following organizations collectively constitute the Cooperating Railway Labor Organizations to whom the policy is issued.

- [International Brotherhood of Boilermakers, Iron Ship Builders, Blacksmiths, Forgers and Helpers
- International Brotherhood of Electrical Workers
- National Conference of Firemen and Oilers/SEIU
- International Association of Machinists and Aerospace Workers
- SMART Mechanical Department
- Transportation Communications Union/IAM
- Brotherhood of Maintenance of Way Employes Division/IBT

- Brotherhood of Railroad Signalmen
- Brotherhood of Locomotive Engineers and Trainmen Division/IBT
- [SMART Transportation Division]
- American Train Dispatchers Association
- Transport Workers Union]

Preferred Provider

A provider who has agreed to discount his or her charges for Covered Services under Plans A, B, C, E, M and P.

Psychologist

A person who specializes in clinical psychology and fulfills one of the following requirements:

- A person licensed or certified as a psychologist.
- A Member or Fellow of the American Psychological Association, if there is no government licensure or certification required.

Wherever reference is made to a licensed physician, it will also include a psychologist.

Railroad Employees National Health and Welfare Plan

Reasonable Charge

An amount measured and determined by UnitedHealthcare by comparing the actual charge with the charges made for similar services and supplies provided to individuals of similar age, sex, circumstances and medical condition in the locality concerned.

In determining the Reasonable Charge for a service or supply that is:

- unusual; or
- not often provided in the same area; or
- provided by only a small number of providers in the area:

Factors such as the following may be taken into account:

- the complexity;
- the degree of skill needed;
- the type of specialty of the provider;
- the range of services or supplies provided by a Facility; and
- the prevailing charge in other areas.

Skilled Nursing Facility

It is an institution which meets the following tests:

- It is operated under the applicable licensing and other laws.
- It is under the supervision of a Physician, or registered graduate nurse (R.N.), who is devoting full time to supervision.

- It is regularly engaged in providing room and board and continuously provides 24 hour a day skilled nursing care of sick and injured persons at the patient's expense during the convalescent stage of an injury or sickness.
- It maintains a daily medical record of each patient who is under the care of a Physician.
- It is authorized to administer medication to patients on the order of a Physician.
- It is not, other than incidentally, a home for the aged, the blind or the deaf, a hotel, a domiciliary care home, a maternity home, or a home for alcoholics or drug addicts or the mentally ill.

Student

The term "Student" as used herein is limited to the Employee's unmarried children 19 years of age but under 25 years of age, who have their legal residence with the Employee, and who are wholly dependent upon the Employee for maintenance and support and who are registered students in regular, full-time attendance at an accredited secondary school, college or university orinstitution for the training of nurses.

TransitAmerica Services, Inc. (TASI) Early Retirement Plan

Transplant Facility

A Hospital that UnitedHealthcare specifically designates as a transplant facility. A Transplant Facility has entered into an agreement with UnitedHealthcare to render Covered Health Services for the treatment of specified diseases or conditions. A Transplant Facility may or may not be located within your geographic area. The fact that a Hospital is a network hospital does not mean that it is a Transplant Facility.

Treatment Center

An institution which does not qualify as a Hospital but which does provide a program of effective medical and therapeutic treatment for alcoholism and/or chemical dependency and meets all the following requirements:

- It is established and operated in accordance with any applicable state law.
- It provides a program of treatment approved by a Physician and UnitedHealthcare.
- It has or maintains a written, specific and detailed regimen requiring full-time residence and full-time participation by the patient.
- It provides at least the following basic services:
  - Room and board.
  - Evaluation and diagnosis.
  - Counseling.
  - Referral and orientation to specialized community resources.

Urgent Care Center

A facility that provides Covered Health Services that are required to prevent serious deterioration of one's health, and that are required as a result of an unforeseen sickness, injury, or the onset of acute or severe symptoms.

[XII]

CLAIM INFORMATION

HOW TO FILE A CLAIM FOR BENEFITS

PLANS A, B AND C

In order for UnitedHealthcare to process your medical claims as fast as possible, the following steps should be taken when you incur medical expenses:

- Send your medical bills to UnitedHealthcare, [P.O. Box 30985, Salt Lake City, UT 84130].
- Generally, medical bills will include information such as employee name, employee address and name of patient which are needed to process your claims. In addition to these items of information, it is very important that the employee's **social security number, policy number** "GA-23111" and **nature of illness or injury** appear on each submission of bills to avoid any unnecessary delay in the payment of your claim.

Upon receipt of your claim, UnitedHealthcare will immediately furnish any additional form required in accordance with the kind of claim presented. In most cases, additional forms will not be required.

PLAN F

Claims under Plan F are paid in UnitedHealthcare's office at [P.O. Box 30304, Salt Lake City, UT 84130]. For expenses not covered under Medicare, send itemized bills to Salt Lake City. Be sure to include the Employee's social security number and the policy number (GA-23111).

To submit claims for expenses also covered under Medicare, the provider of services must first file a claim with Medicare. The Medicare contractor will then send an Explanation of Medicare Benefits (EOMB).

If your Medicare claim is paid in any Medicare office where UnitedHealthcare has arranged for an automatic transfer of Medicare claim information, you will not have to file a separate claim to receive Plan F benefits. Instead, after Medicare processing has been completed, these claims will automatically be filed under Plan F.

If your Medicare claim is not paid in any Medicare office where UnitedHealthCare has arranged for an automatic transfer of Medicare claim information, you will have to file a separate claim with UnitedHealthcare to receive Plan F benefits. To do so, send a copy of the Explanation of Medicare Benefits (EOMB) you receive to UnitedHealthcare's Salt Lake City office. Be sure to include the Employee's name, social security number and policy number (GA-23111) on the EOMB.

You can always know whether your Medicare claim has been automatically transferred to Plan F, or whether you have to file a separate claim to receive Plan F benefits, by looking at your EOMB. Your EOMB will have a message telling you that your claim was forwarded. The message may not specifically tell you that your claim was transferred to UnitedHealthcare, but it will make some reference that it was sent to another carrier. If you do not receive this message on your EOMB, you will have to file a separate claim to receive Plan F benefits.

PLAN E

Benefits will be paid under Plan E automatically with no additional action required on your part. Follow the instructions in your GA-46000 booklet for submission of claims.

PROCESSING OF CLAIMS AND APPEALS

Overview

The claims and appeal procedures under the **Policy** consist of the steps explained below. You must exhaust the internal claims and appeals process as explained below before filing any judicial action against the **Policy** on a claim denied in whole or in part. A "claim" is a request for required pre-approval for care or treatment to be covered by the **Policy** or for reimbursement or payment by the **Policy** for care or treatment you have already received. These claims and appeals procedures also apply to any rescission of coverage, whether or not a claim is involved.

Here is a summary of the process:

Step 1 – You must file an initial claim

This claim will be processed and reviewed within specified time frames, depending on whether it is a "pre-service request" or a "post-service request."

Step 2 – If your claim is denied, you may make an informal inquiry

If your initial claim is denied in whole or in part, you have the opportunity to make an informal inquiry into the reasons for the denial. You should generally receive an answer to your inquiry within 60 days. This informal inquiry process is not mandatory and does not impact your formal appeal rights.

Step 3 – You have the right to a formal appeal if your initial claim is denied

If your initial claim is denied in whole or in part you have two formal appeals levels:

1. The first level of appeal which is required for all claims, must be made to UnitedHealthcare.

2. The second level of appeal is a right that is available to you if you so choose.

Each part of the process is explained more fully below.

Step 1 – Initial Claim Processing

Explanation of Benefits Will be Provided. If, in order to receive full benefits, you request required pre-approval of services involving Urgent Care, you will receive verbal notification followed by a written or electronic Explanation of Benefits informing you of the determination made with regard to your request. For all other claims, you will receive a written or electronic Explanation of Benefits informing you of the benefit determination.

The Explanation of Benefits will be written in a manner that can be understood by you. If the decision is adverse to you, the Explanation of Benefits will contain the following information related to your claim: (1) the reasons for the decision, including a denial code and its corresponding meaning; (2) a description of the standard, if any, that was used in denying the claim; (3) references to specific **Policy** provisions that explain the decision; (4) information sufficient to identify the claim involved (including the date of the service, the health care provider, the claim amount if applicable, and a statement describing the availability, upon request, of the diagnosis and treatment codes and their corresponding meanings); (5) an explanation of any additional material or information that may be necessary to perfect your claim and why that information is necessary; (6) a description of the applicable internal appeal procedure and external review processes; (7) a reference to any rule, guideline, protocol, or similar criterion that was relied upon in making the decision, or a statement that such information will be provided at no charge upon request; (8) either an explanation of the scientific or clinical judgment involved or a statement that

such an explanation will be provided to you at no charge upon request, if the adverse decision is based on a judgment about medical necessity, experimental treatment, or a similar **Policy** exclusion or limitation; (9) a statement about your rights to bring an action in court if the decision is still adverse to you once you complete the appeal process; and (10) contact information for an applicable office of health insurance consumer assistance or ombudsman.

Time Periods and Process for Urgent Care Initial Claims

If you are requesting required pre-approval for Urgent Care in order to obtain full benefits and a prior authorization is involved, then the following will apply:

- A health care professional with knowledge of your medical condition may act as your authorized representative for the purpose of your request.
- If your request was not made properly, you will be provided with verbal notification of the proper procedure for making the request as soon as possible, but no later than 24 hours from the receipt of your request.
- If your request is made properly and all necessary information is included, you will be provided with verbal notification of the determination made upon your request as soon as possible, but no later than 72 hours from the receipt of your request.
- If additional information is required to make a determination on your request, you will be provided with verbal notification of the additional information required to complete your request as soon as possible, but no later than 24 hours from receipt of your request.
    - You will have 48 hours after receipt of this notification to provide the additional information.
    - You will then be provided with verbal notification of the determination on your request as soon as possible, but no later than 48 hours after the earlier of:
        - the receipt of the additional information; or
        - the end of the 48-hour period in which you have to provide the additional information.
- If an Urgent Care request for ongoing treatment was previously approved for a period of time or a number of treatments, and you request an extension of that treatment, you will be provided with verbal notification of the determination on your request as soon as possible, but no later than 24 hours from the receipt of your request, provided your request is made at least 24 hours before the termination of care. Otherwise, you will be provided with verbal notification of the determination no later than 72 hours from the receipt of your request.
- For all requests for required pre-approval of services involving Urgent Care, a written or electronic copy of the determination will be sent to you within 3 days following verbal notification.
- Your request will no longer be processed as involving Urgent Care if you go ahead and receive the care or treatment for which you seek pre-approval. Instead, your request will be processed as a post-service claim for reimbursement.

Time Periods and Process For Non-Urgent Initial Claims

The time periods and process for initial claims depends on whether the claim involves a "pre-service request" or a "post-service request" as explained below.

Pre-Service Requests

If, in order to receive full benefits, you request required pre-approval of care or treatment, the following will apply:

- If your request was not made properly, you will be notified verbally or in writing within 5 days from the receipt of your request of the proper procedure for making the request.

- If your request is made properly, a notice of determination regarding your request will be sent to you no later than 15 days after receipt of your request. UnitedHealthcare may take an additional 15 days to make a determination if it determines that such an extension is necessary for reasons beyond its control and notifies you of this extension within 15 days from the receipt of your request. This notice will give you the reason for the extension and the date by which the determination will be made.

- If an extension is necessary because additional information is required to make the determination, you will be notified of the specific information that is needed.

    - You will have 45 days after receipt of this notice to provide the additional information.

    - The period for making a determination on your request will be suspended until you either provide the necessary information or until the 45-day period for you to provide the information ends, whichever comes first.

- If a request to pre-approve ongoing treatment was previously approved for a period of time or a number of treatments, and UnitedHealthcare wants to reduce or terminate the treatment, you will be notified promptly.

- Your request will no longer be processed as a pre-service request if you go ahead and receive the care or treatment for which you seek pre-approval. Instead, your request will be processed as a post-service claim for reimbursement.

Post-Service Requests

When you seek reimbursement or payment for care or treatment that you have already received, your claim will be handled as follows:

- You will ordinarily be notified as to whether your claim will be paid or denied (in whole or in part) no later than 30 days after the receipt of your claim.

- UnitedHealthcare may take an additional 15 days to make a benefit determination if it determines that such an extension is necessary due to matters beyond its control and notifies you of this extension within 30 days from the receipt of your claim. This notice will give you the reason for the extension and the date by which the benefit determination will be made.

- If additional information is required to make a benefit determination, the notice will state this and identify the additional information required.

    - You have 45 days after receipt of this notice to provide the additional information.

- The period for making a benefit determination on your claim will be suspended until you either provide the necessary information or until the 45-day period for you to provide the information ends, whichever comes first.

Step 2 – Informal Inquiries Following Claim Denials

If a claim has been denied in whole or in part, and you have questions about the reasons for the denial or you disagree with the reasons, you may make an informal inquiry by telephone about the reasons for the denial to UnitedHealthcare.

The Explanation of Benefits that you receive denying your claim in whole or in part will set forth the name and telephone number of the appropriate office to contact if you would like to make an informal inquiry concerning your claim for benefits. You are not required to make an informal inquiry before you initiate any formal appeal, but an informal inquiry could lead you to understand better the reasons for the claim denial, or it could result in a change in the way your claim is handled. Informal inquiries concerning claim denials must be made within 60 days after you receive your Explanation of Benefits and will be addressed promptly.

Step 3 – Formal Appeals of Claim Denials: Rights and Procedures

The formal appeals process for denied claims consists of a first and second level appeal process as explained below.

First Level of Appeal for all Claim Denials – To the Company Administering Your Benefit

If you are dissatisfied with the handling of your claim following informal inquiry, or even if you do not make an informal inquiry, you may make a formal written appeal of a denied claim to UnitedHealthcare.

Your Explanation of Benefits will include information explaining how to initiate this formal appeal and the name and address of the office to which the formal appeal should be sent. All formal appeals must be initiated by a written request for a formal appeal. Your request for a formal appeal must be submitted within one hundred eighty (180) days after you receive your Explanation of Benefits or, if you make a timely informal telephone inquiry concerning the denial of your claim, within one hundred eighty (180) days after you make that informal inquiry.

You may submit additional information with your written request for formal appeal. Your formal appeal may include evidence and testimony, and written comments, documents, records and other information relating to the claim for benefits (regardless of whether such information was considered in the initial claim for benefits). You are also entitled, upon request and at no charge, to receive access to and copies of all documents, records, and other information relevant to your claim, although in some cases approval may be needed for the release of confidential information such as medical records. UnitedHealthcare, considering your formal appeal, will provide you with new or additional evidence considered, relied upon, or generated it, or at its direction and any additional rationale for a denial prior to appeals decision in order to give you a reasonable opportunity to respond to the new evidence or rationale. This information will be provided sufficiently in advance of the date by which UnitedHealthcare must provide the claims denial notice, to give you the opportunity to respond to the new or additional information. The decision made on your appeal will take into account all comments, documents, records, and other information you submit relating to your claim, regardless of whether the information was submitted or considered as part of the initial determination on your claim.

All decisions of first level appeals will be made without any deference to the initial decision on your claim. The individual who decides your formal first level appeal will not be the same person who initially decided your claim, nor will he or she be a subordinate of that person. If the benefits decision under review is based on a medical judgment, the individuals reviewing your appeal will consult with a health care professional who has appropriate training and experience. That health care professional will not be a

person who was consulted in connection with the initial decision on your claim nor will he or she be a subordinate of a person consulted on the initial decision.

You will be notified of the decision on your formal appeal in writing or electronically (except as noted below). The written or electronic notice will be written in a manner calculated to be understood by you, will specify the reasons for the decision, including a denial code and its corresponding meaning, and a description of the standard, if any, that was used in denying your claim, including a discussion of the decision, will contain a reference to specific plan provisions relevant to the decision, and a statement that you may receive, upon request and at no charge, reasonable access to and copies of documents and information relevant to your claim for benefits. The notice will also specify any rule, guideline, or protocol relied on in deciding your appeal, or an offer to provide such rule, guideline or protocol at no charge upon request. The notice will also identify any medical experts whose advice was obtained on behalf of the **Policy** in connection with your claim, even if the advice was not relied on in making a benefit decision. The notice will also include a description of your right to bring an action under ERISA Section 502(a) after you complete the appeal process. You may appeal an adverse decision on your formal first level appeal as described below.

Final (Second Level) Appeal

The second level of the appeal process is explained below. There are two possible second level appeal processes – one for claims that do not involve **Medical Judgment** and one for claims that do involve **Medical Judgment**. A decision on your formal second level appeal will be final, except that you may appeal that decision to a court (see below).

Claims Not Involving Medical Judgment

If you are dissatisfied with the results of any initial appeal of your claim denial to UnitedHealthcare that does not involve **Medical Judgment**, you may file an additional appeal with UnitedHealthcare. Your request for an appeal must be submitted within ninety (90) days after you receive the results from your initial appeal, and the process for filing an appeal will be included with the results from your initial appeal.

Claims Involving Medical Judgment – To an External Independent Review Organization

If your claim involves **Medical Judgment** (excluding those that involve only contractual or legal interpretation without any use of **Medical Judgment**), and you exhaust the first level of appeal procedure (or earlier, if you are deemed to have exhausted such procedure due to the **Policy's** failure to comply with the procedure), you will have the right to request a second level of appeal, which will consist of an independent review with respect to that claim. You must request this appeal/independent review within four months after receiving notice of an adverse benefit determination or final internal adverse benefit determination.

Within five business days after receiving your request, a preliminary review will be completed to determine whether: (i) you are/were covered under the **Policy**; (ii) the denial was based on an issue involving **Medical Judgment**; (iii) you exhausted the internal claims and appeals process, if required; and (iv) you provided all information necessary to process the independent review. Within one business day after completing the preliminary review, you will be notified in writing if your request is not eligible for an independent review or if it is incomplete. If your request is complete but not eligible for independent review, the notice will include the reason(s) for ineligibility. If your request is not complete, the notice will describe any information needed to complete the request. You will have the remainder of the four month filing period or 48 hours after receiving the notice, whichever is greater, to cure any defect. If eligible for an independent review, your request will be assigned to an independent review organization (IRO). The IRO will provide written notice of its final independent review decision within 45 days after the IRO receives the request for independent review. If the IRO reverses the adverse benefit determination or final internal adverse benefit determination, then the Plan will cover the claim.

In addition, you will have the right to an expedited independent review in the following situations:

1. Following an adverse benefit determination involving a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal.

2. Following a final internal adverse benefit determination involving (i) a medical condition for which the timeframe for completion of a standard independent review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function or (ii) an admission, availability of care, continued stay, or health care item or service for which you received emergency services but have not been discharged from a facility.

The IRO will provide notice of its final independent review decision as expeditiously as the claimant's medical condition or circumstances require, but not more than 72 hours after the IRO receives the request.

Formal Appeals of Claim Denials: Timeframes for Receiving a Determination

Following is a summary of the timeframes for receiving a determination on your appeal of a denied claim.

Urgent Care Appeals – Claims Not Involving Medical Judgment

Your appeal may require prompt action if you are appealing the denial of your request for required pre-approval of Urgent Care and a prior authorization is involved. In these situations:

- Your appeal need not be in writing. You or your **Physician** can request a review by telephone. All necessary information, including the decision, will be transmitted verbally, by telephone, by facsimile, or by similar means.

- You will be notified verbally and in writing or electronically as soon as possible, but no later than 72 hours from receipt of your appeal.

- Your appeal will no longer be processed as appealing a denial of a request for pre-approval for urgent care or treatment if you go ahead and receive the care or treatment for which you seek pre-approval. Instead, your appeal will be processed as a post-service claim for reimbursement.

Non-Urgent Care Appeals

Pre-Service

If you are appealing the denial of your request for required pre-approval for medical care services or treatment or the termination or reduction of benefits for medical care or treatment, your appeal will be handled as follows:

- A decision following the review of your first level appeal by UnitedHealthcare will be sent to you within 15 days from the day your appeal of the denial is received.

- If you file a final (second level) appeal with UnitedHealthcare with respect to a claim not involving **Medical Judgment**, a decision will be sent to you within 15 days from the day your appeal is received.

- If you file a final (second level) appeal with respect to a claim involving **Medical Judgment**, the IRO's decision will be sent to you within 45 days from the day your appeal is received by the IRO.

- Your appeal will no longer be processed as appealing a denial of a request for pre-approval for care or treatment if you go ahead and receive the care or treatment for which you seek pre-approval. Instead, your appeal will be processed as a post-service claim for reimbursement.

Post-Service

If you are appealing the denial of benefits for care or treatment that you have already received, your appeal will be handled as follows:

- A decision following the review of your appeal by UnitedHealthcare will be sent to you within 30 days after your appeal of the denial is received.

- If you file a final (second level) appeal with UnitedHealthcare with respect to a claim not involving **Medical Judgment**, a decision will be sent to you within 30 days from the day your appeal is received.

- If you file a final (second level) appeal with respect to a claim involving **Medical Judgment**, the IRO's decision will be sent to you within 45 days from the day your appeal is received by the IRO.

External Appeals

If you have exhausted the appeals process described in this Certificate, and you are still dissatisfied with the resolution of an appeal involving the medical appropriateness of a service, you may contact the Director, Office of the Health Care Ombudsman and Bill of Rights at the following:

For Medical Appropriateness cases:
District of Columbia Department of Health Care Finance
Office of the Health Care Ombudsman and Bill of Rights
825 North Capital Street, N.E.
6th Floor
Washington, DC 20002
Telephone - 1-877-685-6391
Facsimile – 202-478-1397

If you have exhausted the appeals process described in this Certificate, and you are still dissatisfied with the resolution of an appeal involving anything other than the medical appropriateness of a service, you may contact the Commissioner of Insurance at the following:

For Non-Medical Appropriateness cases:
Gennet Purcell, Commissioner
Department of Insurance, Securities and Banking
810 First St., N.E., 7th Floor
Washington, DC 20002
Telephone – 202-727-8000
Facsimile – 202-354-1085

PROOF OF LOSS

UnitedHealthcare may:

- require bills for Hospital confinement and other services as part of the proof of claim.
- examine you or your Dependent in connection with the claim.

Proof must be furnished to UnitedHealthcare no later than 90 days after the loss for which the claim is made. If it is not reasonably possible to furnish the proof in this time it must be furnished at the earliest reasonable possible date.

If your state of residence requires that you have more time to furnish proof, you will have the time allowed by your state.

PAYMENT OF CLAIMS

Employee and Dependents health benefits are payable to the Employee.

Employee and Dependents health benefits which are assigned will be paid to the assignee. The Employee will receive notice of payment of assigned benefits.

All benefits will be paid upon receipt of proper written proof.

ACTIONS

You may not sue on your claim before 60 days after proof of claim has been furnished to UnitedHealthcare or more than three years from the time proof of claim is required.

If your state of residence requires that you have more time to bring suit, you will have the time allowed by your state.

IMPORTANT MESSAGE FOR RETIREES OF KEOLIS COMMUTER SERVICES (FORMERLY MBCR) COVERED UNDER PLAN M

The Keolis Commuter Services (formerly MBCR) Plan is referred to below as your Primary Plan.

PLAN M CLAIM SUBMISSION

To submit claims under Plan M, follow these two steps:

1. First, file a claim under your Primary Plan.
2. After you receive an Explanation of Benefits (EOB) from your Primary Plan, send an itemized bill with a copy of the EOB to UnitedHealthcare, P.O. Box 30985, Salt Lake City, UT 84130-0985. Be sure to include the employee's name, social security number, policy number (GA-23111 Plan M) and nature of the illness or injury with each claim submission.

COBRA CONTINUATION UNDER THE PRIMARY PLAN

Any dependent who elects to continue Primary Plan coverage under COBRA may also continue coverage under Plan M, provided you notify UnitedHealthcare within 30 days of the COBRA election. If you elect to continue Plan M, you must also notify UnitedHealthcare when COBRA coverage ends.

Expenses incurred after Primary COBRA coverage ends for any reason are not Covered Expenses under Plan M. Any Plan M benefits paid for expenses incurred after Primary Plan COBRA coverage ends, due to your failure to notify UnitedHealthcare, are subject to recovery by UnitedHealthcare.

IMPORTANT MESSAGE FOR RETIREES OF AMTRAK AND TRANSITAMERICA SERVICES, INC. (TASI) COVERED UNDER PLAN P

The Amtrak Early Retirement Medical Plan or the TransitAmerica Servicse, Inc. (TASI) Early Retirement Plan is referred to below as your Primary Plan.

PLAN P CLAIM SUBMISSION

To submit claims under Plan P, follow these two steps:

1. First, file a claim under your Primary Plan.
2. After you receive an Explanation of Benefits (EOB) from your Primary Plan, send an itemized bill with a copy of the EOB to UnitedHealthcare, P.O. Box 30985, Salt Lake City, UT 84130-0985. Be sure to include the employee's name, social security number, policy number (GA-23111 Plan P) and nature of the illness or injury with each claim submission.

COBRA CONTINUATION UNDER THE PRIMARY PLAN

Any dependent who elects to continue Primary Plan coverage under COBRA may also continue coverage under Plan P, provided you notify UnitedHealthcare within 30 days of the COBRA election. If you elect to continue Plan P, you must also notify UnitedHealthcare when COBRA coverage ends.

Expenses incurred after Primary COBRA coverage ends for any reason are not Covered Expenses under Plan P. Any Plan P benefits paid for expenses incurred after Primary Plan COBRA coverage ends, due to your failure to notify UnitedHealthcare, are subject to recovery by UnitedHealthcare.

[NOTICE OF PRIVACY PRACTICES

GROUP POLICY GA-23111

Effective Date: September 23, 2013

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We, meaning UnitedHealthcare Insurance Company, as the issuer of Group Policy GA-23111, and any of our affiliated or subsidiary companies, including, but not limited to, United Behavioral Health (collectively referred to herein as "United"), are required by law to protect the privacy of your protected health information. As used in this notice, the terms "We", "Us" and "Our" refer not only to United itself, but also to any agents or contractors acting on its behalf, including those entities that United has retained to administer the benefits it provides. Federal law prohibits Us from disclosing your health information to an agent or contractor unless that agent or contractor has agreed in writing to maintain the privacy of your health information.

We are required to provide this notice. It explains how We use protected health information about you and when We disclose that information to others. Federal law requires Us to use and disclose your protected health information only as described in this notice. We are also required by law to honor your rights with respect to your protected health information that are described in this notice. We are also required to provide you notice promptly if a breach occurs that may have compromised the privacy or security of your information.

The term "protected health information" as used in this notice includes any personal information that relates to your physical or mental health condition, the provision of health care to you, or the payment for such health care. The provisions of this notice apply to protected health information that is created by Us or received by Us from others.

If We make a material change to our privacy practices, We will provide a revised notice or information about the material change and how to obtain a revised notice, to you and it will be provided either by direct mail or electronically, in accordance with applicable law.

We collect and maintain oral, written and electronic information to administer your health plan and to provide products, services and information of importance to enrollees. We maintain physical, electronic and procedural security safeguards in the handling and maintenance of such information, in accordance with applicable state and federal standards, to protect against risks, such as loss, destruction or misuse.

How We Use and Disclose Your Protected Health Information

Required Uses and Disclosures

We must use and disclose your protected health information to provide information:

- To you or a representative with the legal right to act for you;
- To the Secretary of the Department of Health and Human Services, if necessary, to ensure that your privacy is protected; and
- When required by law; for example, a court could order Us to disclose protected health information in its possession for the purpose of litigation.

Permitted Uses and Disclosures

We have the right to use and disclose protected health information to pay for your health care and manage the provision of benefits to you. We will use or disclose your protected health information only as permitted by law, including the federal Privacy Rule for protected health information. For example, We may, consistent with the Privacy Rule, use or disclose your protected health information for the following purposes:

- Payment. Payment activities include, among other things, collecting contributions due to Us and paying for health care services provided to you. For example, We may receive information from a doctor concerning treatment provided to you. We may review that information to evaluate whether the treatment is eligible for coverage under your health plan. We may also use your protected health information for purposes of making preauthorization determinations for certain types of benefits.

- Treatment. We may use or disclose protected health information for the purpose of assisting health care professionals in their efforts to provide you with medical treatment. For example, We may disclose your protected health information to facilitate referrals between doctors or to coordinate your treatment among health care providers.

- Health Care Operations. We may use or disclose protected health information as necessary to operate your health plan and to manage coverage under that plan. For example, We may use your protected health information to analyze trends in the coverage We provide or to set contribution levels. Other ways in which your protected health information may be used for health care operations include quality assessment and improvement activities, audits of performance under the your health plan, cost management and planning-related analyses, review of the qualifications of health care professionals, administration of your health plan's activities in general, and arrangement for medical review or legal services. We may disclose your protected health information to others for the purpose of conducting health care operations. For example, We may contact your doctor to suggest a disease management or wellness program that could help improve your health.

- Communications with You. We may contact you to provide information about health related products or services such as alternative medical treatments available to you under your health plan. We may use your protected health information to identify programs and treatments that would be most beneficial to you. We may also contact you to provide appointment reminders for your medical treatment.

- Disclosures to the Policyholder. Your health plan is governed by the Policyholder. The Policyholder is defined in your health plan's Certificate of Coverage. We may share statistical information about usage under your health plan and enrollment and disenrollment information with the Policyholder. In addition, We may share other protected health information with the Policyholder solely for purposes of plan administration. Neither We nor the Policyholder will share your protected health information with your employer without your express written authorization or as may be permitted under applicable law.

- Underwriting Purposes. We may use or disclose your protected health information for underwriting purposes; however We will not use or disclose your genetic information for such purposes. Generally, genetic information involves information about differences in a person's DNA that could increase or decrease his or her chance of getting a disease (for example, diabetes, heart disease, cancer or Alzheimer's disease).

Other Uses and Disclosures Permitted by Law

We may, consistent with the federal Privacy Rule for protected health information, use or disclose your protected health information for the following purposes under limited circumstances:

- Disclosure for Public Health Purposes. We may be required to disclose your protected health information for public health activities, such as reporting disease outbreaks or adverse reactions caused by a prescription drug.

- Disclosure to Persons Involved with Your Care. We may disclose your protected health information to a person involved in your care, such as a family member, when you are incapacitated or in an emergency, or when permitted by law. Special rules apply regarding when We may disclose protected health information to family members and others involved in a deceased individual's care. We may disclose protected health information to any persons involved, prior to the death, in the care or payment for care of a deceased individual, unless We are aware that doing so would be inconsistent with a preference previously expressed by the deceased.

- Disclosure to Report Abuse, Neglect or Domestic Violence. We may be required to disclose your protected health information to government authorities, including a social service or protective service agency, to help them identify and aid victims of abuse, neglect, or domestic violence.

- Disclosure for Health Oversight Activities. We may be required to disclose your protected health information to government officials responsible for overseeing health insurers, health care providers, government benefit programs, or civil rights laws relating to health care.

- Disclosure in Judicial or Administrative Proceedings. We may be required to disclose your protected health information in response to a court order, search warrant or subpoena or other lawful process.

- Disclosure for Law Enforcement Purposes. We may be required to disclose your protected health information to law enforcement officials for limited purposes, such as missing person investigations.

- Disclosure to Avoid a Serious Threat to Health or Safety. We may be required to disclose your protected health information to public health agencies.

- Disclosure for Workers Compensation. We may be required to disclose protected health information arising out of job-related injuries pursuant to applicable laws.

- Disclosure for Specialized Government Functions. We may be required to disclose limited information for military and veteran activities, national security and intelligence activities, and the protective services for the President and other public officials.

- Use or Disclosure for Research Purposes. We may use or disclose protected health information for research purposes subject to limitations imposed by law.

- Disclosure to Coroners or Medical Examiners. We may disclose protected health information to a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also disclose information to funeral directors as necessary to carry out their duties.

- Disclosure for Organ Procurement Purposes. We may use or disclose information for procurement, banking or transplantation of organs, eyes or tissue.

- Disclosure to Correctional Institutions or Law Enforcement Officials. We may disclose your protected health information if you are an inmate of a correctional institution or under the custody of a law enforcement official, but only if necessary, (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

- Disclosure to Business Associates. We may disclose your protected health information to our business associates that perform functions on your health plan's behalf or provide your health plan with services, if the protected health information is necessary for such functions or services. Our business associates are required, under contract with Us and pursuant to federal law, to protect the privacy of your protected health information and are not allowed to use or disclose any information other than as specified in Our contract and as permitted by federal law.

- Disclosure for Data Breach Notification Purposes. We may disclose your contact information to provide legally-required notices of unauthorized acquisition, access, or disclosure of your protected health information. We, or Our business associates, may send notice directly to you.

Whenever We disclose your protected health information for a purpose permitted by the federal Privacy Rule, We are required to disclose only the minimum amount of information necessary to serve that purpose.

If none of the above reasons applies, **then We must get your written authorization to use or disclose your protected health information.** This includes, except for limited circumstances allowed by federal privacy law, not using or disclosing psychotherapy notes about you, selling your protected health information to others, or using or disclosing your protected health information for certain promotional communications that are prohibited marketing communications under federal law, without your written authorization. Once you authorize disclosure of your protected health information, We cannot guarantee that the person to whom the information is provided will not disclose the information. You may revoke your written authorization, unless We have already acted based on your authorization. To revoke an authorization, contact the privacy office identified below.

In some states, state law may impose restrictions on the use or disclosure of protected health information more stringent than those described in this notice. For example, some states may require plans to obtain a person's express authorization before using or disclosing his or her protected health information for the purposes described above. We will comply with such state laws to the extent they apply to your health plan.

Your Rights with Respect to Your Protected Health Information

The following are your rights with respect to your protected health information.

- Restrictions on Uses and Disclosures of Your Protected Health Information. You have the right to ask Us to agree to restrictions on the uses or disclosures We make of your protected health information for purposes of treatment, payment, or health care operations. You also have the right to ask Us to impose restrictions on disclosures of your protected health information to family members or to others who are involved in your health care or payment for your health care. While We will try to honor your request and will permit requests consistent with Our policies, We are not required to agree to any restriction. If We determine that We cannot accommodate your request to restrict uses or disclosures of your protected health information for the purposes of treatment, payment, or health care operations, We will provide you with reasonable notice of Our decision.

- Restrictions on Methods of Communications from Us. You have the right to ask Us to restrict Our communications with you to a more confidential mode of communication or to contact you at a different address. We will accommodate reasonable requests to communicate in a confidential format.

- Inspection of Protected Health Information. You have the right to inspect and obtain a copy of certain protected health information maintained about you by Us, such as claims and case or medical management records. If We maintain your protected health information electronically, you will have the right to request that We send you a copy of your protected health information in an electronic format. You can also request that We provide a copy of your information to a third party that you identify. You also may receive a summary of this protected health information. A request to inspect or copy your protected health information, or have your information sent to a third party, must be made in writing to the address provided below. In certain limited circumstances, We may deny your request to inspect and copy your protected health information. We may impose a reasonable fee reflecting the actual costs of copying, mailing or preparing a summary of your protected health information.

- Amendment of Protected Health Information. You have the right to ask Us to amend certain protected health information We maintain about you, such as claims and case or medical management records, if you believe that the information is inaccurate or incomplete. You must make such a request in writing to the address provided below. If We deny your request, you may have a statement of your disagreement added to your protected health information.

- Accounting of Disclosures of Protected Health Information. You have the right to ask Us to provide you with an accounting of certain disclosures of your protected health information made by Us during the six years prior to your request. This accounting will not include disclosures of information: (i) made for treatment, payment, and health care operations purposes; (ii) made to you or pursuant to your authorization; (iii) made to correctional institutions or law enforcement officials; or (iv) other disclosures for which federal law does not require Us to provide an accounting.

- Paper Copy of This Notice. You may ask for a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

How to Exercise Your Rights

- Contacting Us. For further information about the privacy of your protected health information, to obtain a copy of this notice, or to ask Us to agree to restrict the ways in which it uses or discloses your protected health information, contact Our privacy compliance officer at the following address or phone number:

  UnitedHealthcare
  Customer Service – Privacy Unit
  P.O. Box 30985
  Salt Lake City, UT 84130
  Tel: 1-800-842-5252

- Filing a Complaint. If you believe your privacy rights have been violated, you may file a written complaint with Us at the following address:

  UnitedHealthcare
  Customer Service – Privacy Unit
  P.O. Box 30985
  Salt Lake City, UT 84130

You may also notify the Secretary of the U.S. Department of Health and Human Services if you feel We have violated your rights. You can file a complaint with the U.S. Department of Health Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20001, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

We will not take any action against you for filing a complaint.

- Exercising Your Rights With Respect to Your Protected Health Information. You are entitled to inspect, copy or amend certain protected health information maintained by or on behalf of Us, to request an accounting of disclosures of certain protected health information, or to ask that communications from Us be made in a confidential manner or place.]

INFORMATION REQUIRED BY THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (“ERISA”)

The following information together with this booklet form the Summary Plan Description under the Employee Retirement Income Security Act of 1974, sometimes called "ERISA."

- Name of Plan:

  Group Health Insurance Plans For Former Railroad Employees and their Dependents Provided Under Group Policy GA-23111

- Plan Identification Numbers:

  Employer Identification Number (EIN): 53-6001877
  Plan Number (PN): 503

- Plan Administrator:

  Cooperating Railway Labor Organizations
  c/o Transportation Communications Union/IAM
  3 Research Place
  Rockville, MD 20850

  The Plan Administrator has authority to control and manage the operation and administration of the Plan and is the agent for service of legal process.

- Type of administration of the Plan: The Plan is administered directly by the Plan Administrator.

  The Plan’s offerings are provided primarily by the Plan named above with claims being paid by UnitedHealthcare Insurance Company, Hartford, Connecticut 06103 in accordance with the provisions of the Group Policy GA-23111 issued by UnitedHealthcare Insurance Company, Hartford, Connecticut 06103.

- Funding:

  The Plan is funded by premium payments made directly to UnitedHealthcare by individuals covered under the Plan, as required by the insurance policies.

- Source of contributions to the Plan:

  Premium payments made by individuals covered under the Plan.

- Date of the end of the Plan Year:

  Each Plan Year ends on a May 31.

- Claim Procedures:

  See pages [151] through [155] of this Certificate for requirements as to notice and proof of claim.

- How to Appeal a Claim:

  See pages [155] through [158] of this Certificate for what action to take when appealing a claim.

- Plan Amendment and Termination:

  The Cooperating Railway Labor Organizations have the right to modify, suspend, terminate, withdraw or amend the Plan in whole or in part at any time. Amendments to the Plan must be adopted by a majority of the Organizations' members and evidenced by a written instrument signed by the Chairman of the Organizations.

  In event of termination of the Plan, the assets of the Plan will be used towards payment of obligations of the Plan and any remaining surplus will be distributed in the manner determined by the Plan Administrator to best effectuate the purposes of the Plan in accordance with the applicable regulations under ERISA.

As a participant in the Plan, you are entitled to certain rights and protections under ERISA, which provides that all Plan participants shall be entitled to:

- **Receive Information About Your Plan and Benefits**

  - Examine, without charge, at the Plan Administrator's office and at other locations, all documents governing the Plan, including insurance contracts and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions.

  - Obtain, upon written request to the Plan Administrator, copies of all Plan documents and other Plan information. The administrator may make a reasonable charge for the copies.

  - Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary financial report.

- **Continue Group Health Coverage**

  - Continue health care coverage for you or your dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. See the section of this Certificate that sets forth your **COBRA** continuation of coverage rights.

  - Reduce or eliminate exclusionary periods of coverage for preexisting conditions under the Plan, if any, as long as you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from the Plan or UnitedHealthcare when you lose coverage under the Plan, when you become entitled to elect **COBRA** continuation coverage, or when your **COBRA** continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage.

- **Prudent Action by Plan Fiduciaries**

  In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries," of the Plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

- **Enforce Your Rights**

  If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any detail, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights.

  - For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

  - If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court, but not until you exhaust the appeals process described in this Certificate.

  - In addition, if you disagree with the Plan’s decision or lack thereof, concerning the qualified status of a medical child support order, you may file suit in Federal court, but not until you exhaust the appeals process described in this Certificate.

  - If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file a suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

- **Assistance with Your Questions**

  If you have any questions about the terms of the Plan or about the proper payment of benefits, you may obtain more information from the company described in this Certificate as administering the benefit program in which you participate or contact the Plan Administrator. If you have any questions about whether you are covered, you may obtain that information from your employer.

  If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

* * *

UnitedHealthcare does not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to the Civil Rights Coordinator.
Online: UHC_Civil_Rights@uhc.com
Mail: Civil Rights Coordinator. UnitedHealthcare Civil Rights Grievance. P.O. Box 30608 Salt Lake City, UT 84130

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again. If you need help with your complaint, please call the toll-free phone number listed on your ID card, TTY 711, [Monday through Friday, 8 a.m. to 8 p.m].

You can also file a complaint with the U.S. Dept. of Health and Human Services.
Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.
Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)
Mail: U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201

We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call the toll-free phone number listed on your ID card TTY 711, [Monday through Friday, 8 a.m. to 8 p.m.].

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Please call the toll-free phone number listed on your identification card.

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número de teléfono gratuito que aparece en su tarjeta de identificación.

請注意：如果您說中文(Chinese)，我們免費為您提供語言協助服務。請撥打會員卡所列的免付費會員電話號碼。

XIN LƯU Ý: Nếu quý vị nói tiếng **Việt (Vietnamese)**, quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi số điện thoại miễn phí ở mặt sau thẻ hội viên của quý vị.

알림: **한국어(Korean)**를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 신분증 카드에 기재된 무료 회원 전화번호로 문의하십시오.

PAALALA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numero ng telepono na nasa iyong identification card.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **русском (Russian)**. Позвоните по бесплатному номеру телефона, указанному на вашей идентификационной карте.

تنبيه: إذا كنت تتحدث **العربية (Arabic)**، فإن خدمات المساعدة اللغوية المجانية متاحة لك. الرجاء الاتصال على رقم الهاتف المجاني الموجود على معرّف العضوية.

ATANSYON: Si w pale **Kreyòl ayisyen (Haitian Creole)**, ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nimewo gratis ki sou kat idantifikasyon w.

ATTENTION : Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro de téléphone gratuit figurant sur votre carte d'identification.

UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny numer telefonu podany na karcie identyfikacyjnej.

ATENÇÃO: Se você fala **português (Portuguese)**, contate o serviço de assistência de idiomas gratuito. Ligue gratuitamente para o número encontrado no seu cartão de identificação.

ATTENZIONE: in caso la lingua parlata sia l'**italiano (Italian)**, sono disponibili servizi di assistenza linguistica gratuiti. Per favore chiamate il numero di telefono verde indicato sulla vostra tessera identificativa.

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte rufen Sie die gebührenfreie Rufnummer auf der Rückseite Ihres Mitgliedsausweises an.

注意事項：**日本語(Japanese)**を話される場合、無料の言語支援サービスをご利用いただけます。健康保険証に記載されているフリーダイヤルにお電話ください。

توجه: اگر زبان شما **فارسی (Farsi)** است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. لطفا با شماره تلفن رایگانی که روی کارت شناسایی شما قید شده تماس بگیرید.

कृपा ध्यान दें: यदि आप **हिंदी (Hindi)** भाषी हैं तो आपके लिए भाषा सहायता सेवाएं नि:शुल्क उपलब्ध हैं। कृपा अपने पहचान पत्र पर दिए टाल-फ़्री फ़ोन नंबर पर काल करें।

CEEB TOOM: Yog koj hais Lus **Hmoob (Hmong)**, muaj kev pab txhais lus pub dawb rau koj. Thov hu rau tus xov tooj hu deb dawb uas teev muaj nyob rau ntawm koj daim yuaj cim qhia tus kheej.

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយ**ភាសាខ្មែរ (Khmer)** សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទទៅលេខឥតគិតថ្លៃ ដែលមាននៅលើអត្តសញ្ញាណប័ណ្ណរបស់អ្នក។

PAKDAAR: Nu saritaem ti **Ilocano (Ilocano)**, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan iti toll-free a numero ti telepono nga nakalista ayan iti identification card mo.

DÍÍ BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yáníłti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shǫǫdí ninaaltsoos nitł'izí bee nééhozinígíí bine'dęę' t'áá jíík'ehgo béésh bee hane'í biká'ígíí bee hodíilnih.

OGOW: Haddii aad ku hadasho **Soomaali (Somali)**, adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac lambarka telefonka khadka bilaashka ee ku yaalla kaarkaaga aqoonsiga.

NOTES

SERFF Tracking #:	*UHLC-130805292*	***State Tracking #:***		***Company Tracking #:***	*50086886 (1/17)*

State:	*District of Columbia*	***Filing Company:***	*UnitedHealthcare Insurance Company*
TOI/Sub-TOI:	*H21 Health - Other/H21.000 Health - Other*		
Product Name:	*2017 Railroad COC Filing*		
Project Name/Number:	*/*		

Supporting Document Schedules

Satisfied - Item:	Statement of Variability
Comments:	
Attachment(s):	SOV_50086886.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Flesch Certification
Comments:	
Attachment(s):	Flesch Certification.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Redlines to previously approved form
Comments:	
Attachment(s):	50086886_1.17 - redline.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Cover Letter 11.11.16
Comments:	
Attachment(s):	Cover Letter 11.11.16.pdf
Item Status:	
Status Date:	

UnitedHealthcare Insurance Company

Statement of Variability
for
RailRoad Schedule of Benefits (Form No. 50086886)

General Variable Information

The page numbers at the bottom of the pages are bracketed to allow these numbers to be consecutive in the *Schedule of Benefits* that is issued to the Subscribers and the Enrolling Group.

Specific Variable Information

The following tables provide a description of how and/or when each variable in the will be used.

PAGE NUMBER(S)	SUBSECTION TITLE	VARIABLE USE
1	*Middle of the Page*	The effective date is bracketed to allow an eligible person to be covered when they are eligible for the plan.
8-9	*Benefit Summary Plans A, B, C*	[1] Annual Deductible, Annual Out of Pocket Maximum, Policy Lifetime Maximum Benefit, Inpatient Hospital and Related Services, Medical Services/Physician's Office Visit, Outpatient Rehab, Allergy, Emergency Room Services, Durable Medical Equipment, Home Health Care Services, Hospice Facility, Skilled Nursing Facility, Emergency Transportation Services are all filed with ranges to accommodate when Rail Road wants to offer a different plan design. [2]Include when the plan design is based on a Policy year basis. This is determined by the Enrolling Group.
11	*Benefit Summary Plan F*	[1]Include dollar amount for Foreign Emergency Care Benefit. [2]Include dollar amount for Preventive Medical Care Expense Benefits.
12	*Benefit Summary Plans E, M & P*	[1]Include dollar amount for Maximum Amount per Lifetime. [2]Include dollar amount for Cash Deductible per calendar year. [3]Include dollar amount for Out-of-Pocket Maximum per calendar year. [4]Include Percentage of Covered Expenses payable.

UnitedHealthcare Insurance Company
Hartford, Connecticut
NAIC #79413

CERTIFICATION OF COMPLIANCE/READABILITY

This is to certify that the accompanying forms comply with your state's readability requirements:

A. **Option Selected**
The forms are scored separately for the Flesch reading ease test. Scores are indicated below.

Form Number	Flesch Score
50086886 (1/17)	50.3

B. **Test Option Selected**
Test was applied to each entire policy form.

C. **Standards for Certification**
A checked block indicates the standard has been achieved.

X 1. The form text achieves a minimum score of 40 on the Flesch reading ease test in accordance with the option chosen in Section A above.

X 2. It is printed in not less than ten point type, one point leaded.

X 3. The style, arrangement and overall appearance of the policy give no undue prominence to any portion of the text of the policy or to any endorsements or riders.

X 4. The section titles are captioned in bold face type or otherwise stand out significantly from the text, if the policy has more than three thousand words printed on three or fewer pages of text, or if the policy has more than three pages regardless of the number of words.

X 5. Unnecessarily long, complicated or obscure words, sentences, paragraphs or constructions are not used in the forms.

Date: 11/11/16

Carmel Colica, Assistant Secretary

CERTIFICATE OF COVERAGE

for inactive railroad and union Employees and their Dependents who are eligible for Health Benefits Plans offered by:

COOPERATING RAILWAY LABOR ORGANIZATIONS

(called the Policyholder)

insured by

UNITEDHEALTHCARE INSURANCE COMPANY
Hartford, Connecticut
(called the Company)

UnitedHealthcare Insurance Company has issued Group Policy No GA-23111 to the Policyholder, Cooperating Railway Labor Organizations, consisting of the separate organizations shown on page 2 of this Certificate. The Policy covers retired railroad workers as provided through collective bargaining agreements established by the signatories to the Policy as listed on page 2.

This Certificate of Coverage describes the benefits and provisions of the Policy.

This is an Employee's Certificate of Coverage only while that Employee is insured under the Policy. Dependent benefits apply only if the inactive railroad or union Employee is insured under this Plan for Dependent benefits.

This Certificate describes the Plans in effect as of [January 1, 2017]. It is void if issued to any other Employee.

This Certificate replaces any and all Certificates previously issued for this Policy.

UNITEDHEALTHCARE INSURANCE COMPANY

[Jeffrey Alter, President]

[50086886 (1/17)]

THE GROUP HEALTH PLANS DESCRIBED IN THIS CERTIFICATE OF COVERAGE ARE AVAILABLE TO INACTIVE EMPLOYEES OF, OR REPRESENTED BY THE FOLLOWING COOPERATING RAILWAY LABOR ORGANIZATIONS SIGNATORY TO GROUP HEALTH POLICY GA-23111

[International Brotherhood of Boilermakers, Iron Ship Builders, Blacksmiths, Forgers and Helpers

International Brotherhood of Electrical Workers

National Conference of Firemen and Oilers/SEIU

International Association of Machinists and Aerospace Workers

SMART Mechanical Department

Transportation Communications Union/IAM

Brotherhood of Maintenance of Way Employes Division/IBT

Brotherhood of Railroad Signalmen

Brotherhood of Locomotive Engineers and Trainmen Division/IBT

SMART Transportation Division

American Train Dispatchers Association

Transport Workers Union]

THE PLANS ARE ALSO AVAILABLE TO CERTAIN EMPLOYEES REPRESENTED BY OTHER ORGANIZATIONS.

Table of Contents

INTRODUCTION

The Plans included in this Certificate have been made available by the Railway Labor Organizations to provide benefits under Group Policy GA-23111 for Employees and Dependents formerly covered under the ~~Health & Welfare Plan~~Railroad Employees National Health and Welfare Plan, the NRC/UTU Plan, GA-46000, GA-107300, the Amtrak Early Retirement Plan, the Keolis Commuter Services (formerly Massachusetts Bay Commuter Railroad MBCR) Early Retirement Plan, or the TransitAmerica Services, Inc. (TASI) Early Retirement Plan, and for parents of Employees currently covered under one of these plans.

Some of the terms used in this Certificate need explanation because they have specialized or important meanings for the purposes of the Group Policy. When any of these terms is used in this Certificate, it will have the meaning shown for that term in the Definitions section of this Certificate of Coverage. Refer to this section whenever you have a question about any of the terms listed below.

Alternate Care Plan

Ambulatory Surgical Center

Amtrak Early Retirement Plan

Assistant Surgeon Services

Birth Center

Chemotherapy

COBRA

Convenient Care Clinic

Covered Health Services

Custodial Care

Dependent

Durable Medical Equipment

Employee

Experimental or Investigational or Unproven Service(s)

Full Medicare Coverage

Furloughed Employee

GA-107300

GA-46000

~~Health & Welfare Plan~~

Home Health Care Agency

Hospice

Hospital

Inactive Employee

Keolis Commuter Services (formerly MBCR) Early Retirement Plan

Level of Care

Medical Judgment

Medically Appropriate

Medicare

Multiple Surgical Procedures

Nurse-Midwife

NRC/UTU Plan

Person Eligible Under Medicare

Physician

Policy

Policyholder

Preferred Providers

Psychologist

Railroad Employees National Health and Welfare Plan

Reasonable Charge

Skilled Nursing Facility

Student

TransitAmerica Services, Inc. (TASI) Early Retirement Plan

Transplant Facility

Treatment Center

Urgent Care Center

Whenever the pronouns "he", "his", or "him" appear in this text, they refer equally to the female as well as the male gender.

II
SUMMARY OF THE GROUP POLICY

The benefits described in this Certificate are for U.S. residents only. Here is a brief summary of the eligibility and benefit provisions of Group Policy GA-23111. The detailed description of these provisions is contained later in this Certificate of Coverage.

ELIGIBILITY SUMMARY

When your coverage under the ~~Health & Welfare Plan~~Railroad Employees National Health and Welfare Plan, the NRC/UTU Plan, GA-46000, GA-107300, the Amtrak Early Retirement Plan, the Keolis Commuter Services (formerly MBCR) Early Retirement Plan, or the TransitAmerica Services, Inc. (TASI) Early Retirement Plan terminates, you may enroll in Plan A, B, C, E, F, M or P for yourself and/or your Dependents in accordance with the following:

Plans A, B and C are for all persons eligible for coverage under GA-23111 except Persons Eligible Under Medicare, and persons eligible under GA-46000 the Amtrak Early Retirment Plan, the Keolis Commuter Services (formerly MBCR) Early Retirement Plan or the TransitAmerica Services, Inc. (TASI) Early Retirement Plan.

Plan E is for persons eligible under GA-46000 or any other group health plan which is determined by UnitedHealthcare Insurance Company to provide benefits identical to GA-46000.

Plan F is for Persons Eligible Under Medicare. Each person must be enrolled separately and a separate premium paid under Plan F.

Plan M is for persons eligible under the Keolis Commuter Services (formerly MBCR) Early Retirement Plan.

Plan P is for persons eligible under the Amtrak Early Retirement Plan, the TransitAmerica Services, Inc. (TASI) Early Retirement Plan or any other group health plan which is determined by UnitedHealthcare Insurance Company to provide benefits identical to the Amtrak Early Retirement Plan.

BENEFITS SUMMARY – PLANS A, B AND C

Benefit	Policy GA-23111		
	Plan A	**Plan B**	**Plan C**
Annual Deductible (applies to OOP deductible)	[$500 – 3,000]	[$500 – 3,000]	[$500 – 3,000]
Annual Out of Pocket Maximum	[$5,000 – 30,000]	[$5,000 – 30,000]	[$5,000 – 30,000]
Policy Lifetime Maximum Benefit	[$200,000 - unlimited]	[$200,000 - unlimited]	[$200,000 - unlimited]
Inpatient Hospital and Related Services (includes maternity) **Inpatient Mental Health and Substance Abuse Services** **Surgical Procedures (Surgeon, Anesthesiology and Facility, including Ambulatory Surgical Center and Outpatient Surgical Center)**	[40 - 60]% of eligible expenses after satisfying deductible.	[50 - 70]% of eligible expenses after satisfying deductible.	[60 - 80]% of eligible expenses after satisfying deductible.
Medical Services/ Physician's Office Visit	[40 - 60]% of eligible expenses after satisfying deductible. 100% of eligible expenses without coinsurance or deductible for the following: Mammography and Pap Smear.	[50 - 70]% of eligible expenses after satisfying deductible. 100% of eligible expenses without coinsurance or deductible for the following: Mammography and Pap Smear.	[60 - 80]% of eligible expenses after satisfying deductible. 100% of eligible expenses without coinsurance or deductible for the following: Mammography and Pap Smear.
Outpatient Mental Health and Substance Abuse services	75% of eligible expenses after satisfying deductible for the first 40 visits, 60% for any visits thereafter.	75% of eligible expenses after satisfying deductible for the first 40 visits, 60% for any visits thereafter.	75% of eligible expenses after satisfying deductible for the first 40 visits, 60% for any visits thereafter.
Outpatient Rehabilitation (physical, occupational, speech therapy and Chiro)	[40 - 60]% of eligible expenses after satisfying deductible. *Limited to 30 visits per calendar year. Exception: Calendar year visit limit does not apply to services for a child under age 21 with a congenital or birth defect.	[50 - 70]% of eligible expenses after satisfying deductible. *Limited to 30 visits per calendar year. Exception: Calendar year visit limit does not apply to services for a child under age 21 with a congenital or birth defect.	[60 - 80]% of eligible expenses after satisfying deductible. *Limited to 30 visits per calendar year. Exception: Calendar year visit limit does not apply to services for a child under age 21 with a congenital or birth defect.
Allergy/Acupuncture Services	[40 - 60]% of eligible expenses after satisfying deductible.	[50 - 70]% of eligible expenses after satisfying deductible.	[60 - 80]% of eligible expenses after satisfying deductible.

Benefit	Policy GA-23111		
	Plan A	**Plan B**	**Plan C**
Emergency Room Services	[40 - 60]% of eligible expenses after satisfying deductible.	[50 - 70]% of eligible expenses after satisfying deductible.	[60 – 80]% of eligible expenses after satisfying deductible.
Durable Medical Equipment Prior notification is required for items over $1,000.*	[40 - 60]% of eligible expenses after satisfying deductible.	[50 - 70]% of eligible expenses after satisfying deductible.	[60 - 80]% of eligible expenses after satisfying deductible.
Prescription Drugs	Not Covered	Not Covered	Not Covered
Home Health Care Services*	[40 - 60]% of eligible expenses after satisfying deductible up to 30 visits per calendar year.	[50 - 70]% of eligible expenses after satisfying deductible up to 30 visits per calendar year.	[60 - 80]% of eligible expenses after satisfying deductible up to 30 visits per calendar year.
Hospice Facility*	[40 - 60]% of eligible expenses after satisfying deductible for up to a period of six (6) months.	[50 - 70]% of eligible expenses after satisfying deductible for up to a period of six (6) months.	[60 - 80]% of eligible expenses after satisfying deductible for up to a period of six (6) months.
Skilled Nursing Facility	[40 - 60]% of eligible expenses after satisfying deductible for up to [20-60] days per confinement; confinement applies to skilled nursing facility only.	[50 - 70]% of eligible expenses after satisfying deductible for up to [20-60] days per confinement; confinement applies to skilled nursing facility only.	[60 - 80]% of eligible expenses after satisfying deductible for up to [20-60] days per confinement; confinement applies to skilled nursing facility only.
Emergency Transportation Services	[40 - 60]% of eligible expenses after satisfying deductible for ambulance service to a hospital in the event of an emergency.	[50 - 70]% of eligible expenses after satisfying deductible for ambulance service to a hospital in the event of an emergency	[60 - 80]% of eligible expenses after satisfying deductible for ambulance service to a hospital in the event of an emergency.
Exclusions (partial list):	Hearing Wisdom Teeth Orthodontics Massage Therapy	Hearing Wisdom Teeth Orthodontics Massage Therapy	Hearing Wisdom Teeth Orthodontics Massage Therapy

** Requires prior notification – Care Coordination must be contacted to determine whether the purchase, rental of equipment or services provided are Medically Appropriate.*

PLAN A

Major Medical Expense Benefits

Maximum Amount per lifetime – [$200,000 - unlimited]

Cash Deductible per calendar year – [$500 - $3000]

Out-of-Pocket Maximum per calendar year – [$5,000 - $30,000]

Percentage of Covered Expenses payable – [40-60]% ([20-40]% if Care Coordination is not called when required).

Percentage of Covered Expenses payable after Out-of-Pocket Maximum is reached - 100% ([70-90]% if Care Coordination is not called when required)

PLAN B

Major Medical Expense Benefits

Maximum Amount per lifetime - [$200,000 - unlimited]

Cash Deductible per calendar year – [$500 - $3,000]

Out-of-Pocket Maximum per calendar year – [$5,000 - $30,000]

Percentage of Covered Expenses payable – [50-70]% ([30-50]% if Care Coordination is not called when required).

Percentage of Covered Expenses payable after Out-of-Pocket Maximum is reached - 100% ([70-90]% if Care Coordination is not called when required)

PLAN C

Major Medical Expense Benefits

Maximum Amount per lifetime – [$200,000 - unlimited]

Cash Deductible per calendar year – [$500 - $3,000]

Out-of-Pocket Maximum per calendar year – [$5,000 - $30,000]

Percentage of Covered Expenses payable – [60-80]% ([40-60]% if Care Coordination is not called when required).

Percentage of Covered Expenses payable after Out-of-Pocket Maximum is reached - 100% ([70-90]% if Care Coordination is not called when required)

PLAN F

Hospital Expense Benefits

For confinements up to 90 days:

- the Medicare Part A Deductible for the first 60 days;
- the Medicare Part A daily coinsurance amount for the 61st to the 90th day.

For confinements over 90 days:

- any Medicare Part A coinsurance amount when lifetime reserve days are used;
- up to 365 days of Hospital charges in a person's lifetime after all lifetime reserve days are used.

Skilled Nursing Facility Expense Benefits

The Medicare Part A daily coinsurance amount for the 21st to the 100th day of a Medicare approved confinement.

Medical Expense Benefits

The amount of the Medicare Part B deductible.

The amount of the Medicare Part B coinsurance.

The amount of the Medicare Part B limiting charge when a physician or provider does not accept a Medicare assignment.

The Medicare blood deductible.

Foreign Emergency Care Benefits

[80%] of charges for necessary emergency care in a foreign country up to a lifetime maximum of $[25,000 - $200,000].

At-Home Recovery Care Expense Benefits

Up to [$1,600] per year for short-term at-home assistance with activities of daily living for those recovering from an illness, injury or surgery.

Preventive Medical Care Expense Benefits

Up to [$100 - $2,000] per year for preventive screening tests or preventive services.

Treatment Center Expense Benefits

Confinements in a Treatment Center:

- 60 days per Calendar Year.
- 12 days per Calendar Year for detoxification services.

PLAN E / PLAN M / PLAN P

Major Medical Expense Benefits

Maximum Amount per lifetime – [$500,000 - $1,000,000]

Cash Deductible per calendar year – [$100 - $2500]

Out-of-Pocket Maximum per calendar year – [$5,000 - $30,000]

Percentage of Covered Expenses payable:

- All expenses except Outpatient Alcoholism, Chemical Dependency and/or Mental Illness Services - [60-80]%
- Expenses for Outpatient Alcoholism, Chemical Dependency and/or Mental Illness Services - 75% for the first 40 visits, 60% for any visits thereafter

Percentage of Covered Expenses payable after the Out-of-Pocket Maximum is reached - 100%

Treatment Center Expense Benefits

Confinements in a Treatment Center:

- 60 days per Calendar Year.
- 12 days per Calendar Year for detoxification services.

ALL PLANS

Under federal law, benefits may not be restricted for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, benefits may be paid for a shorter stay if the attending provider (e.g., your Physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

If the mother agrees, the attending provider may discharge the mother and/or newborn child earlier than these minimum time frames.

In all cases of early discharge, coverage shall be provided for post-delivery care within the minimum time periods shown above in the Employee's home, or, in a provider's office, as determined by the Physician in consultation with the mother.

The at-home post-delivery care shall be provided by a registered professional nurse, Physician, nurse-practitioner, nurse-midwife, or physician assistant experienced in maternal and child health, and shall include:

- parental education;
- assistance and training in breast or bottle feeding; and
- performance of any necessary and clinically appropriate tests, including the collection of an adequate sample for hereditary and metabolic newborn screening.

Additional benefits may be available to you or your Dependents depending on your state of residence. For more information contact [UnitedHealthcare, Railroad Administration, 450 Columbus Boulevard, P. O. Box 150476, Hartford, CT 06115-0476].

In addition, any provision of this Certificate which, on its effective date, is in conflict with the statutes of the jurisdiction in which you reside on such date, is hereby amended to conform to the minimum requirements of such statutes.

III
ENROLLMENT AND PAYMENT PROCEDURES

WHO MAY ENROLL

EMPLOYEES AND DEPENDENTS

GA-23111 enrollment is available to certain Employees and their Dependents, when their employer group health coverage ends. This employer group health coverage must have been provided under one of the following plans:

- ~~Health & Welfare Plan~~Railroad Employees National Health and Welfare Plan;
- GA-46000;
- Amtrak Early Retirement Plan;
- Keolis Commuter Services (formerly MBCR) Early Retirement Plan;
- TransitAmerica Services, Inc. (TASI) Early Retirement Plan;
- GA-107300;
- NRC/UTU Plan; or
- Any other health and welfare plan established pursuant to an agreement between one or more railroads and one or more labor organizations.

GA-23111 is also available to former Railway Industry Employees, and their Dependents, who were not covered under one of the above listed plans, but who are members in accordance with the constitution or by-laws of one of the participating railway labor organizations, when coverage under the employer group health plan which applies to them ends.

If you live outside of the United States of America, you are not eligible for the coverage provided in this Certificate.

Important Message for Hospital Association Employees

If your Employee health benefits were provided by a hospital association while you were actively working, you may enroll for Employee benefits under GA-23111 only:

- If you are retired and do not qualify for benefits similar to GA-46000, the Amtrak Early Retirement Plan, the Keolis Commuter Services (formerly MBCR) Early Retirement Plan, or the TransitAmerica Services, Inc. (TASI) Early Retirement Plan through the hospital association, or
- If you are not retired, but are not actively at work, your membership in the hospital association is discontinued.

If you do qualify for benefits similar to GA-46000, the Amtrak Early Retirement Plan, the Keolis Commuter Services (formerly MBCR) Early Retirement Plan, or the TransitAmerica Services, Inc. (TASI) Early Retirement Plan through the hospital association, you can enroll for Employee benefits under GA-23111 when you become eligible for Medicare.

In the event Dependent benefits end under GA-107300 because a widow or a widower remarries, the surviving spouse, and any surviving dependent children, may enroll for Dependent benefits under GA-23111.

If you have questions about when your active group health coverage ends, please refer to the booklet titled The Railroad Employees National Health and Welfare Plan or the National Railway Carriers & United Transportation Union Health & Welfare Plan.

In order to determine when coverage ends under GA-46000 or GA-107300, refer to your benefits booklet for these plans, or call UnitedHealthcare at 1-800-842-5252.

In order to determine when coverage ends under the Amtrak Early Retirement Plan, the Keolis Commuter Services (formerly MBCR) Early Retirement Plan, or the TransitAmerica Services, Inc. (TASI) Early Retirement Plan, refer to the benefit booklet for those plans or call the number listed in those plans for more information.

In order to determine when your coverage under any other employer group health plan ends, refer to your benefits booklet, or call a representative of that plan.

If you are a Suspended or a Dismissed Employee enrolled under GA-23111, and if you are awarded full back pay for all time lost as a result of your suspension or dismissal, you may be entitled to a refund of the premiums you paid under GA-23111. If this occurs, you should contact UnitedHealthcare for additional information.

STUDENTS AND INCAPACITATED CHILDREN

Dependent benefits under Plans A, B, C, E and M cover children age 19 or over who are Students or who are incapacitated. Therefore if you are enrolling for Dependent benefits under Plans A, B, C, E or M, you are not required to enroll these children separately unless the child is eligible under Medicare. However, proof of Student or incapactitated status may be required. When incapacitated children are no longer eligible for Dependent benefits under Plans A, B, C, E or M, they must be enrolled separately, and an additional payment is required.

Dependent benefits under Plan P cover children through the end of the month in which they reach age 26, regardless of their student status. If you are enrolling for Dependent benefits under Plan P, you are not required to enroll these children separately unless the child is eligible under Medicare. Coverage for incapacitated children may continue beyond age 26 if the child's coverage is continued under the Amtrak Early Retirement Plan or the TransitAmerica Services, Inc. (TASI) Early Retirement Plan.

PARENTS OF EMPLOYEES COVERED UNDER THE ~~HEALTH & WELFARE PLAN~~RAILROAD EMPLOYEES NATIONAL HEALTH AND WELFARE PLAN, THE NRC/UTU PLAN, GA-46000, THE AMTRAK EARLY RETIREMENT PLAN, THE KEOLIS COMMUTER SERVICES (FORMERLY MBCR) EARLY RETIREMENT PLAN, THE TRANSITAMERICA SERVICES. INC. (TASI) EARLY RETIREMENT PLAN, GA-23111 AND GA-107300

Employees covered under the ~~Health & Welfare Plan~~Railroad Employees National Health and Welfare Plan, the NRC/UTU Plan, GA-46000, the Amtrak Early Retirement Plan, the Keolis Commuter Services (formerly MBCR) Early Retirement Plan, the TransitAmerica Services, Inc. (TASI) Early Retirement Plan, GA-23111 or GA-107300 may enroll under Plan F to provide benefits for parents and parents-in-law who are eligible under Medicare.

WHEN TO ENROLL

There is an initial four month period during which you or your Dependents may enroll under GA-23111. This initial four month period begins in the month in which your employer group health coverage ends, and extends for the next three months. If you have questions about when your active group health coverage ends, please refer to ~~the booklet titled The Railroad Employees National Health and Welfare Plan, GA-107300 or the National Railway Carriers & United Transportation Union Health & Welfare Plan~~your coverage document for your prior group health plan coverage.

If you did not enroll during your initial four month period, a second four month period is available when you or any individual Dependent first becomes eligible for Medicare. This second four month period begins in the month immediately prior to your Medicare eligibility date, and extends for the next three months.

Two examples may help explain these two enrollment periods:

1. If you are covered under the ~~Health & Welfare Plan~~Railroad Employees National Health and Welfare Plan or the NRC/UTU Plan and you leave compensated service on [September 30, 2017] to retire, your Employee and Dependents health benefits under that plan would end [October 31, 2017]. Your initial four month period begins [October 1, 2017] and ends [January 31, 2018].

2. If you did not enroll under GA-23111 during your initial four month period, you have a second four month period beginning in the month prior to the month you become eligible for Medicare. If your Medicare eligibility date is [October 1, 2017], your second four month period begins [September 1, 2017] and ends [December 31, 2017]. If your spouse's Medicare eligibility date is [March 1, 2018], your spouse's second four month period begins [February 1, 2018] and ends [May 31, 2018].

If you or your Dependents are continuing your employer group health coverage under COBRA, your initial four month enrollment period begins in the month in which your COBRA continuation coverage ends.

If you are enrolling your parents or parents-in-law under GA-23111, there is only an initial four month enrollment period. It begins as follows:

- If your parent or parent-in-law is already eligible for Medicare when you first become covered under the ~~Health & Welfare Plan~~Railroad Employees National Health and Welfare Plan, the NRC/UTU Plan, GA-46000, the Amtrak Early Retirement Plan, the Keolis Commuter Services (formerly MBCR) Early Retirement Plan, the TransitAmerica Services, Inc. (TASI) Early Retirement Plan, GA-23111 or GA-107300, your four month period begins in your first month of coverage.

- If your parent or parent-in-law becomes eligible for Medicare after you become covered under any of these plans, your four month period begins in the month prior to the month of your parent's or parent-in-law's Medicare eligibility date.

If you do not enroll during your initial or second four month enrollment period, you may enroll during a subsequent Open Enrollment Period.

SPECIAL ENROLLMENT PERIODS

You and/or your Dependents may be able to enroll during a special enrollment period, which is the first thirty (30) days immediately following a special enrollment event. A special enrollment period is not available to you or your Dependents if coverage under the prior plan was terminated for cause, or because premiums were not paid on a timely basis.

A special enrollment period applies to you and your Dependents when one of the following events occurs:

- Birth.
- Legal adoption of an eligible child or the placement of a child with you for adoption.
- Marriage.

A special enrollment period also applies for you or your Dependents who did not enroll under the Policy if the following are true:

- You or your Dependents had existing health coverage under another plan at the time you/they had an opportunity to enroll under the Policy; and
- Coverage under the prior plan ended because of any of the following:
    - Loss of eligibility (including, but not limited to, legal separation, divorce or death).
    - The employer stopped paying the contributions. This is true even if you or your Dependents continue to receive coverage under the prior plan and pay the amounts previously paid by the employer.
    - In the case of COBRA continuation coverage, the coverage ended.
    - You or your Dependents no longer live or work in an HMO service area if no other benefit option is available.
    - The plan no longer offers benefits to a class of individuals that include you and/or your Dependents.
    - You or your Dependents incur claims that would exceed a lifetime limit on all benefits.

When an event takes place (for example, a birth or marriage), coverage begins on the date of the event. For you and your Dependents who did not enroll under the Policy because you/they had existing health coverage under another plan, coverage begins on the day immediately following the day coverage under the prior plan ends.

You must notify UnitedHealthcare within thirty (30) days of the occurrence of any of the special enrollment events. If you do not notify UnitedHealthcare within that timeframe, you will not be able to enroll yourself or your Dependents under the Policy until the next Open Enrollment Period.

You will be responsible for any increase in your monthly premium due to the addition of a new Dependent to the Policy (i.e., going from employee only, to employee plus spouse, etc.)

IMPORTANT MESSAGE FOR PERSONS ELIGIBLE UNDER MEDICARE

No person may enroll under Plan F if that person is covered under any one of the programs called Medicare Advantage Plans (formerly called Medicare+Choice). These programs are described in the Medicare Handbook *Medicare & You*.

Any individual covered under Plan F who subsequently enrolls under any of the programs called Medicare Advantage cannot continue coverage under Plan F beyond the effective date of the individual's coverage under the Medicare Advantage plan. You must notify UnitedHealthcare if you become covered under a Medicare Advantage plan.

If you cancel coverage under any of the Medicare Advantage plans with a cancellation effective date of December 31, you may enroll under Plan F, with an effective date of January 1 of the following year. You may enroll in December or January for a January 1 effective date under these circumstances, provided you notify UnitedHealthcare within 30 days of your Medicare Advantage plan cancellation, you provide documentation that your coverage under that plan was cancelled, and you make the January payment for coverage under Plan F.

If you cancel your Medicare Advantage plan at any other point during a calendar year, you will only be able to enroll in Plan F during an Open Enrollment Period.

If you lose your Medicare Advantage coverage because the plan closes and you return to Medicare, you can enroll in Plan F provided you notify UnitedHealthcare within 30 days of the termination. You must provide documentation showing the plan closed to all individuals, such as a letter from the plan or a public notice of the closure in a newspaper.

OPEN ENROLLMENT PERIOD

An Open Enrollment Period is held [no less frequently than for a thirty day period in [month][in November and December] of each even calendar year ([2018, 2020], etc.), and there may be additional special enrollment periods. Enrollments during the Open Enrollment Period are for coverage beginning on the 1st day of the month following the end of the Open Enrollment Period.

HOW TO ENROLL

1. Fill out and sign the enrollment form. If you do not have an enrollment form, you can obtain one by calling UnitedHealthcare at 1-800-842-5252 or online on the Your Track to Health website at www.yourtracktohealth.com. Please be sure all employment information on the form is completed. In selecting the person(s) to be covered and the plan on the reverse side of the form, remember the following:

- Plans A, B and C are only available to Employees and Dependents who are not eligible under Medicare or GA-46000, the Amtrak Early Retirement, the Keolis Commuter Services (formerly MBCR) Early Retirement Plan, or the TransitAmerica Services, Inc. (TASI) Early Retirement Plan.
- Each Person Eligible Under Medicare may enroll in Plan F. This includes children who are eligible under Medicare. If your spouse is enrolled under Plan F, your Dependent children must be separately enrolled under Plans A, B or C in order to be covered under GA-23111.
- You must be covered under GA-46000 in order to be eligible under Plan E. Eligibility requirements for GA-46000 are described in the GA-46000 booklet. If you meet the eligibility requirements for GA-46000, but you or one of your Dependents is eligible for Medicare, you or that Dependent must enroll under Plan F in order to be covered under GA-23111.

- You must be covered under the Keolis Commuter Services (formerly MBCR) Early Retirement Plan in order to be eligible under Plan M. If you meet the eligibility requirements for the Keolis Commuter Services (formerly MBCR) Early Retirement Plan, but you or one of your Dependents is eligible for Medicare, you or that Dependent must enroll under Plan F in order to be covered under GA-23111.
- You must be covered under the Amtrak Early Retirement Plan or the TransitAmerica Services, Inc. (TASI) Early Retirement Plan in order to be eligible under Plan P. If you meet the eligibility requirements for the Amtrak Early Retirement Plan or the TransitAmerica Services, Inc. (TASI) Early Retirement Plan, but you or one of your Dependents is eligible for Medicare, you or that Dependent must enroll under Plan F in order to be covered under GA-23111.

3. Mail the completed enrollment form with check or money order in the amount required, as specified on the form, to UnitedHealthcare in accordance with the instructions on the enrollment form.

4. After you have enrolled for coverage **you must notify** UnitedHealthcare whenever:
   - One of your children reaches age 19 and qualifies as either a Student (under Plans A, B, C, E or M) or as an incapacitated child under any of the Plans.
   - You or one of your Dependents becomes eligible for Medicare due to disability or end stage renal disease.

   Coverage for each Person Eligible Under Medicare will not be continued under Plans A, B, C, E, M or P as of the date of Medicare eligibility. Coverage for such Employee or Dependent will be automatically transferred to Plan F at age 65.

   IMPORTANT: If you or your Dependent becomes eligible under Medicare before age 65, you **must** notify UnitedHealthcare and send a copy of your Medicare card so that continued coverage, if desired, can be transferred to Plan F.

5. If you return to compensated service, and you again become covered under an employer group health plan, you should:
   - Make no further premium payments under GA-23111.
   - Advise us of your return to work date, and the date your employer group health plan coverage becomes effective, by writing to UnitedHealthcare, Railroad Administration, 450 Columbus Boulevard, P. O. Box 150476, Hartford, CT 06115-0476.

EFFECTIVE DATE OF COVERAGE

If you enroll in the first or second month of your initial four month period, your GA-23111 coverage will be effective beginning on the day after your coverage under the employer group health plan ends. You will have no gap in coverage between plans.

If you enroll in the third or fourth month of your initial four month period, your GA-23111 coverage will be effective on the first day of the month following your enrollment. You will have a gap between the date your coverage under the employer group health plan ends, and the date your GA-23111 coverage begins.

If you enroll in the first or second month of your second four month period, your GA-23111 coverage will be effective on your Medicare effective date.

If you enroll in the third or fourth month of your second four month period, your GA-23111 coverage will be effective on the first day of the month following your enrollment.

If you are enrolling your parents or parents-in-law who are already eligible for Medicare when you first become covered under the ~~Health & Welfare Plan~~Railroad Employees National Health and Welfare Plan, NRC/UTU Plan, GA-46000, the Amtrak Early Retirement Plan, the Keolis Commuter Services (formerly MBCR) Early Retirement Plan, the TransitAmerica Services, Inc. (TASI) Early Retirement Plan, GA-23111 or GA-107300, your GA-23111 coverage will always be effective on the first day of the month following your enrollment.

If you are enrolling your parents or parents-in-law who become eligible for Medicare after you become covered under the ~~Health & Welfare Plan~~Railroad Employees National Health and Welfare Plan, NRC/UTU Plan, GA-46000, the Amtrak Early Retirement Plan, the Keolis Commuter Services (formerly MBCR) Early Retirement Plan, or the TransitAmerica Services, Inc. (TASI) Early Retirement Plan, GA-23111 or GA-107300, the rules stated above applicable to the second four month period will apply.

If you enroll during an Open Enrollment Period, your coverage will be effective on the first of the following month.

For the purposes of determining the effective date of GA-23111 coverage, your enrollment occurs when your completed Enrollment Form and payment is mailed (postmarked) to UnitedHealthcare.

For newborn coverage, benefits are payable for a newborn child for 31 days after the child's birth, even if the Employee has not enrolled the child. In order to cover the child beyond the 31 days, the Employee must enroll the child within those 31 days from the date of the birth.

PREMIUM PAYMENT PROCEDURES

Premiums under GA-23111 must be paid on a monthly basis.

You will be paying for coverage one month in advance. You will receive a "Notice of Payment Due" no later than the first week of each month. The payment is due by the 20th of that month, and will provide coverage for the following month.

With each "Notice of Payment Due" you will also receive a "Certification of Coverage-Payment Receipt." This form will acknowledge your previous payment and certify your coverage during the current month. It can be used as an identification card for hospitals and other providers of medical services.

If any monthly payment is not received by UnitedHealthcare by the due date shown on the "Notice of Payment Due," your next "Notice of Payment Due" will request payment for both the current month (which is past due) and the following month. If the past due amount is not paid, coverage will terminate as described in Termination of Coverage section.

You may choose to make your monthly payments via Electronic Funds Transfer (EFT) if you wish to have payments automatically deducted from your checking or savings account. Please contact UnitedHealthcare for further information on this option or visit the Your Track to Health website at www.yourtracktohealth.com for an Automatic Withdrawal / EFT Application.

TERMINATION OF COVERAGE

If you are billed monthly and do not pay any amount shown as past due, your coverage will terminate. You will **not** receive an additional notice. The termination will be effective as of the end of the last month for which payment has been received by UnitedHealthcare.

You may voluntarily terminate your coverage at any time by giving advanced notice in writing to UnitedHealthcare, P.O. Box 150476, Hartford, CT 06115-0476. Your termination will be effective on the first day of the month following the month in which your notice is received by UnitedHealthcare, unless your request clearly states a preferred advanced termination date.

OPTIONAL CONTINUATION OF HEALTH COVERAGE UNDER COBRA

This part of your Certificate contains important information about your right to **COBRA** continuation coverage, which is a temporary extension of coverage under the Plan. **The material in this section generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

The right to **COBRA** continuation coverage was created by a federal law, the Consolidated Omnibus Reconciliation Act of 1985 (**COBRA**). **COBRA** continuation coverage can become available to you when you would otherwise lose your coverage under the **Policy**. It can also become available to other members of your family who are covered under the **Policy** when they would otherwise lose their coverage under this **Policy**. What follows is only a summary of your **COBRA** continuation rights. For additional information about your rights and obligations under the **Policy** and under federal law, you should contact Railroad Enrollment Services toll free at 1-800-842-5252.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of **Policy** coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed below. After a qualifying event, **COBRA** continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the **Policy** is lost because of the qualifying event. Under the **Policy**, qualified beneficiaries who elect **COBRA** continuation coverage must pay for **COBRA** continuation coverage.

If you are the spouse of an **Employee**, you will become a qualified beneficiary if you lose your coverage under the **Policy** because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse becomes entitled to **Medicare** benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the **Policy** because any of the following qualifying events happens:

- The parent-**Employee** dies;
- The parent-**Employee** becomes entitled to **Medicare** (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the **Policy** as a "dependent child."

When is COBRA Coverage Available?

The **Policy** will offer **COBRA** continuation coverage to qualified beneficiaries only after Railroad Enrollment Services has been notified that a qualifying event has occurred.

You Must Give Notice of Qualifying Events

When there is a qualifying event (death of the Employee, the Employee becomes entitled to Medicare benefits (under Part A, Part B or both), divorce or legal separation of the Employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify Railroad Enrollment Services within 60 days after the qualifying event occurs. The notice must be in writing and must be sent to the following address:

Railroad Enrollment Services
Railroad Administration (COBRA)
P.O. Box 30791
Salt Lake City, UT 84130-0791

How is COBRA Coverage Provided?

Once Railroad Enrollment Services receives notice that a qualifying event has occurred, **COBRA** continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect **COBRA** continuation coverage. Covered **Employees** may elect **COBRA** continuation coverage on behalf for their spouses, and parents may elect **COBRA** continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of the coverage you lost as a result of the qualifying event. When the qualifying event is the death of the **Employee**, the **Employee's** becoming entitled to **Medicare** benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, **COBRA** continuation coverage lasts for up to a total of 36 months.

Disability Extension of 18-Month Period of Continuation Coverage

If you or anyone in your family covered under the **Policy** is determined by the Social Security Administration to be disabled, or has a total and permanent disability entitling him or her to an annuity under the Railroad Retirement Act, and you notify Railroad Enrollment Services of the determination within sixty (60) days from the date it was made, you and your entire family may be entitled to receive up to an additional 11 months of **COBRA** continuation coverage, for a total maximum of 29 months. The disability would have to have started at some point before the 60th day of **COBRA** continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

Second Qualifying Event Extension of 18-Month Period of Continuation Coverage

If your family experiences another qualifying event while receiving 18 months of **COBRA** continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of **COBRA** continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to Railroad Enrollment Services. This extension may be available to the spouse and any dependent children receiving continuation coverage if the **Employee** or former employee dies, becomes entitled to **Medicare** (Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the **Policy** as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the **Policy** had the first qualifying event not occurred.

If You Have Questions

Questions about your **Policy** or your **COBRA** continuation coverage rights should be addressed to Railroad Enrollment Services. For more information about your rights under ERISA, including **COBRA**, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.

Keep Railroad Enrollment Services Informed of Address Changes

In order to protect your family's rights, you should keep Railroad Enrollment Services informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to Railroad Enrollment Services.

IV

PLAN A

APPLICABLE TO PERSONS NOT ELIGIBLE UNDER MEDICARE, GA-46000, THE AMTRAK EARLY RETIREMENT MEDICAL PLAN, THE KEOLIS COMMUTER SERVICES (FORMERLY MBCR) EARLY RETIREMENT PLAN OR THE TRANSITAMERICA SERVICES, INC. (TASI) EARLY RETIREMENT PLAN

MAJOR MEDICAL EXPENSE BENEFITS

The Plan pays a percentage of Covered Expenses incurred in a calendar year which exceed the Deductible.

DEDUCTIBLE

The Deductible amount is [$500 - $3,000]. It applies separately to each covered individual each calendar year.

PERCENTAGE OF COVERED EXPENSES PAYABLE

The Plan pays [40% - 60%] (75% for the first 40 outpatient visits for alcoholism, chemical dependency and/or mental illness, and 60% for any visits thereafter) of the Covered Expenses in a calendar year after the Deductible is satisfied.

The Plan pays [20-40]% of the Covered Expenses in a calendar year after the Deductible is satisfied when Care Coordination is not called when required. See the Care Coordination description contained in this Section IV.

The Plan pays 100% of Covered Expenses in a calendar year after the Out-of-Pocket Maximum is met. ([70-90]% if Care Coordination is not called when required.)

OUT-OF-POCKET MAXIMUM

The Out-of-Pocket Maximum limits the amount of Covered Expenses you will have to pay for any one covered individual in a calendar year. The Out-of-Pocket Maximum is [$5,000 - $30,000] each calendar year. Covered Expenses used to satisfy your Deductible are also used to help satisfy your Out-of-Pocket Maximum.

The following expenses do not count in determining if any Out-of-Pocket Maximum has been met:

- Charges you pay that are in excess of the Reasonable Charge.
- Charges you pay that are in excess of specific Plan limits or exclusions.
- Charges you pay for expenses not covered by the Plan.
- [Charges you pay as a result of the reduction in benefits payable when Care Coordination is not notified or if the service or supply, although a Covered Health Service, is not Medically Appropriate.]

MAXIMUM AMOUNT

The Maximum Amount payable with respect to you or any of your Dependents is [$200,000 - unlimited]. The Maximum Amount applies to a person's entire lifetime and is a combined lifetime maximum under Plans A, B and C.

The Maximum Amount for anyone who has received benefits will be restored each January 1 by $1,000, or lesser amount, until the maximum is again [$200,000 - unlimited].

COVERED EXPENSES

Covered Expenses are the actual cost to you of the Reasonable Charges (see Definitions) for Covered Health Services (see Definitions) and supplies listed below. The service or supply must be needed because of injury, sickness or pregnancy.

A service or supply is not a Covered Health Service just because it is furnished by, or ordered by, your provider. The services and supplies will be reviewed by UnitedHealthcare to determine if they are considered Covered Health Services.

Acupuncture Services

Acupuncture services for the following conditions:

- Pain therapy, when another method of pain management has failed.
- Nausea that is related to surgery, pregnancy or chemotherapy.

Acupuncture services must be performed in an office setting by a provider who is one of the following, either practicing within the scope of his/her license (if state license is available) or who is certified by a national accrediting body:

- Doctor of Medicine
- Doctor of Osteopathy
- Acupuncturist
- Chiropractor
- Physician's Assistant

Allergy Immunotherapy Received in a Physician's Office

Benefits are available for allergy immunotherapy received in a Physician's office.

Ambulatory Surgical Center

Charges for services and supplies furnished in an Ambulatory Surgical Center in connection with a surgical procedure within 24 hours from and in connection with the surgical procedure.

Anesthetics

Applied Behavioral Analysis Services

Applied Behavioral Analysis (ABA) services for Autism Spectrum Disorders that are:

- Focused on the treatment of core deficits of Autism Spectrum Disorder;
- Provided by a *Board Certified Applied Behavioral Analyst (BCBA)* or other qualified provider under the appropriate supervision; and
- Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property, and impairment in daily functioning.

Services include the following:

- Diagnostic evaluations, assessment and treatment planning.
- Treatment and/or procedures.
- Medication management and other associated treatments.
- Individual, family, and group therapy.
- Provider-based case management services.
- Crisis intervention.

[Assistant Surgeon

Coverage for assistant surgeon services are limited to 1/5 of the amount of the Reasonable Charge for the surgeon's charge for the surgery. An assistant surgeon must be a Physician. Surgical assistant's services are covered at the same or lesser rate.]

Chemotherapy

Clinical Trials

Routine patient care costs incurred during participation in an approved clinical trial meeting the approved clinical trial criteria stated below.

Benefits include the reasonable and necessary items and services used to diagnose and treat complications arising from participation in an approved clinical trial.

Benefits are available only when the Covered Family Member is clinically eligible for participation in the clinical trial as defined by the researcher. Benefits are not available for preventive clinical trials.

Routine patient care costs for clinical trials include:

- Covered Health Services for which benefits are typically provided absent a clinical trial.
- Covered Health Services required solely for the provision of the investigational item or service, the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications.
- Covered Health Services needed for reasonable and necessary care arising from the provision of an investigational item or service.

Routine costs for clinical trials do not include:

- The Experimental or Investigational Service or item. The only exceptions to this are:
  - Certain Category B devices
  - Certain promising interventions for patients with terminal illnesses.
  - Other items and services that meet specified criteria in accordance with UnitedHealthcare's medical policy guidelines.
- Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.
- Items and services provided by the research sponsors free of charge for any person enrolled in the trial.

To be an approved clinical trial, a clinical trial must meet all of the following criteria:

- Be approved and funded in full or in part by one or more of the following:
  - National Institutes of Health (NIH). (Includes National Cancer Institute (NCI).)
  - Centers for Disease Control and Prevention (CDC).
  - Agency for Healthcare Research and Quality (AHRQ).
  - Centers for Medicare and Medicaid Services (CMS).
  - A bona fide clinical trial cooperative group, including the National Cancer Institute Clinical Trials Cooperative Group, the National Cancer Institute Community Clinical Oncology Program, the AIDS Clinical Trials Group, and the Community Programs for Clinical Research in AIDS.
  - The Department of Defense (DOD), the Department of Veterans Affairs, or the Department of Energy, or a qualified nongovernmental research entity to which the National Cancer Institute has awarded a support grant.
  - A study or investigation approved by the Food and Drug Administration (FDA), including those conducted under an investigational new drug or device application reviewed by the FDA.
  - An investigation or study approved by an Institutional Review Board registered with the Department of Health and Human Services that is associated with an institution that has a federal-wide assurance approved by the Department of Health and Human Services specifying compliance with federal regulations.
- The clinical trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (IRBs) before participants are enrolled in the trial. We may, at any time, request documentation about the trial to confirm that the clinical trial meets current standards for scientific merit and has the relevant IRB approvals.

The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Service and is not otherwise excluded under the Policy.

Convenient Care Clinic

Diabetes Treatment

Coverage for diabetic equipment, diabetes supplies and in-person outpatient diabetic self-management training and education programs (including medical nutrition therapy) when provided under the direction of a Physician by a certified, registered or licensed health care professional.

Diabetes self-management training includes training provided to a Covered Person after the initial diagnosis in the care and management of that condition, including nutritional counseling and proper use of diabetes equipment and supplies. Coverage is also provided for additional training upon diagnosis of a significant change in medical condition that requires a change in the self-management regime, and a periodic continuing education training as warranted by the development of new techniques and treatment for diabetes.

Durable Medical Equipment

Durable Medical Equipment that meets each of the following criteria:

- Ordered or provided by a Physician for outpatient use primarily in a home setting.
- Used for medical purposes.
- Not consumable or disposable except as needed for the effective use of covered Durable Medical Equipment.
- Not of use to a person in the absence of a disease or disability.

Examples of Durable Medical Equipment include:

- Equipment to assist mobility, such as a standard wheelchair.
- A standard Hospital-type bed. Non-hospital beds, comfort beds, and motorized beds/mattresses are generally excluded from coverage.
- Oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks).
- Delivery pumps for tube feedings (including tubing and connectors).
- Braces, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are considered Durable Medical Equipment and are a Covered Health Service. Braces that straighten or change the shape of a body part are orthotic devices, and are excluded from coverage. Dental braces are also excluded from coverage.
- Mechanical equipment necessary for the treatment of chronic or acute respiratory failure (air-conditioners, humidifiers, dehumidifiers, air purifiers and filters, and personal comfort items are excluded from coverage).
- Burn garments.
- Insulin pumps and all related necessary supplies.
- Wigs, but only for loss of hair resulting from treatment of a malignancy or permanent loss of hair from an accidental injury, and up to a maximum of [$500 per calendar year].
- Speech aid prosthetics and traceo-esophaeal voice prosthetics. All other devices and computers to assist in communication and speech are not considered Durable Medical Equipment.
- External prosthetic devices that replace a limb or body part.

Benefits under this section do not include:

- Durable Medical Equipment provided to you by a Physician.
- Generally, any device, appliance, pump, machine stimulator, or monitor that is fully implanted into the body.

If you have any questions regarding whether a particular item is considered to be Durable Medical Equipment, please contact Care Coordination.

Care Coordination must be contacted for any purchase or rental of Durable Medical Equipment that exceeds [$1,000]. UnitedHealthcare will decide if the equipment should be purchased or rented.

Benefits that are available for repairs and replacement, except that:

- Benefits for repair and replacement do not apply to damage due to misuse, malicious breakage or gross neglect.
- Benefits are not available to replace lost or stolen items.
- Replacement of Durable Medical Equipment is limited to every three years, unless there are catastrophic circumstances, in which case you should notify UnitedHealthcare and an individual case evaluation will be performed.

If more than one piece of Durable Medical Equipment can meet your functional needs, benefits are available only for the equipment that meets the minimum specifications for your needs. If you rent or purchase a piece of Durable Medical Equipment that exceeds this guideline, you will be responsible for any cost difference between the piece you rent or purchase and the piece that UnitedHealthcare has determined is the most cost-effective.

Emergency Transportation Services

Transportation charges are covered for transportation to a Hospital in connection with an emergency.

The transportation services must be to a Hospital in your local area. If there are no local Hospitals that can provide the care needed, charges for transportation to the nearest Hospital outside your local area qualified to give the required treatment, will be covered.

Habilitative Services

Habilitative Services for children from birth to age 21 are covered, except for Habilitative Services provided in early intervention and school services.

Habilitative Services includes services, including occupational therapy, physical therapy, and speech therapy, for the treatment of a child with a congenital or genetic birth defect to enhance the child's ability to function. For purposes of Habilitaitive Services, a cogenital or genetic birth defect means a defect existing at or from birth, including a hereditary defect. A congential or genetic birth defect includes, but is not limited to (a) autism or autism spectrum disorder, and (b) cerebral palsy.

Home Health Care Agency Services

Charges for services of a Home Health Care Agency prescribed in writing by a Physician to be in lieu of Hospital confinement, up to a maximum of 30 visits during any one calendar year. Each visit by a member of a home health care team will be considered as one home health care visit. Four hours of home health care services will be considered as one home health care visit. If a visit exceeds four hours, each additional four hours, or part thereof, will count as one additional visit. Each visit by any other member of the home health care team will count as an additional visit.

The following services and supplies of a Home Health Care Agency are covered:

- Temporary or part-time nursing care by or supervised by a registered graduate nurse (R.N.).
- Temporary or part-time care by a home health aide.
- Physical therapy, occupational therapy or speech therapy.
- Medical supplies.
- Drugs and medications ordered by a Physician.
- X-ray and laboratory tests.

Hospice

Hospice care that is recommended by a Physician, for a period of up to six (6) months. Hospice care is an integrated program that provides comfort and support services for the terminally ill. Hospice care includes physical, psychological, social and spiritual care for the terminally ill person and short-term grief counseling for immediate family members while the patient is receiving hospice care.

You must notify and receive approval from Care Coordination prior to receiving any inpatient or outpatient hospice care in order to be eligible for this benefit.

Benefits are available when hospice care is received from a licensed hospice agency.

A Physician must certify that the patient is terminally ill and that the patient's life expectancy is six (6) months or less.

Hospital Services

Services and supplies provided by a Hospital on an inpatient basis, except that if charges are made for a private room, Covered Expenses will be limited to the hospital's average daily charge for a semi-private room.

Coverage is provided for up to 60 inpatient days per calendar year for alcoholism, chemical dependency and/or mental illness services. In addition, coverage is provided for up to 12 days per calendar year for inpatient detoxification services.

Coverage is also provided for newborn infant hearing screenings and all necessary audiological examinations provided as recommended by the national Joint Committee on Infant Hearing. For purposes of this coverage, "Hospital" shall include birthing centers or other centers having newborn nurseries.

Services and supplies provided by a Hospital on an outpatient basis including:

- Emergency care and treatment for a medical emergency, including the sudden onset or worsening of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent lay person, who possesses an average knowledge of health and medicine to result in:
  - Placing the patient's health in serious jeopardy;
  - Serious impairment to bodily functions; or
  - Serious dsyfunction of any bodily organ or part.
- Voluntary HIV screening test performed while receiving emergency care in a Hospital, once per calendar year, regardless of whether or not the HIV screening test is necessary for the treatment of the condition for which the emergency care is sought.

Medical Supplies

- Medical and surgical supplies (such as bandages and dressings). Supplies given during surgery or a diagnostic procedure are included in the overall cost for that surgery or diagnostic procedure.
- Blood or blood derivatives only if not donated or replaced.

Multiple Surgical Procedures

When more than one surgical procedure is performed during the same operative session, Covered Expenses are limited as follows:

- Covered Expenses for the second procedure will be limited to 50% of the Reasonable Charge for that procedure had it been performed alone.
- Covered Expenses for any subsequent procedure are limited to 50% of the Reasonable Charge for the subsequent procedures.

Organ/Tissue Transplants

- Donor Charges

  In the case of an organ or tissue transplant, no services or supplies for the donor are considered Covered Health Services unless the recipient is the Employee or his/her Dependent. If the recipient is not the Employee or his/her Dependent, no benefits are payable for donor charges.

  The search for bone marrow/stem cell from a donor who is not biologically related to the patient is not considered a Covered Health Service UNLESS the search is made in connection with a transplant procedure arranged by a Transplant Facility.

- Qualified Procedures

  If a qualified procedure, listed below, is Medically Appropriate and performed at a Transplant Facility, the "Medical Care and Treatment" and "Transportation and Lodging" provisions set forth below apply:

    - Heart transplants
    - Heart/lung transplants
    - Liver transplants
    - Kidney transplants
    - Pancreas transplants
    - Kidney/pancreas transplants
    - Bone marrow/stem cell transplants
    - Other transplant procedures when UnitedHealthcare determines that it is necessary to perform the procedure at a Treatment Facility.

  If a transplant, even if determined to be Medically Appropriate, is not performed at a Transplant Facility, there will be no benefit payable for the "Medical Care and Treatment" or the "Transportation and Lodging" provisions set forth below.

- Medical Care and Treatment
  - The following services provided in connection with the transplant are Covered Health Services:
    - Pre-transplant evaluation for one of the procedures listed above
    - Organ acquisition and procurement
    - Hospital and Physician fees
    - Transplant procedures
    - Follow-up care for a period up to one year after the transplant
    - Search for bone marrow/stem cell from a donor who is not biologically related to the patient. If a separate charge is made for a bone marrow/stem cell search, a maximum benefit of $25,000 is payable for all charges made in connection with the search.

- Transportation and Lodging

  Care Coordination will assist the patient and family with travel and lodging arrangements. Expenses for travel, lodging and meals for the transplant recipient and a companion are available under this Plan as follows:

  - Reasonable and necessary expenses for transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of the transplant for the purposes of an evaluation, the transplant procedure or necessary post-discharge follow-up.
  - Reasonable and necessary expenses for lodging and meals for the patient (while not confined) and one companion. Benefits are paid at a per diem rate of up to $50 for one person or up to $100 for two people.

  Travel and lodging expenses are only available if the transplant recipient resides more than 50 miles from the Transplant Facility.

  If the Dependent who is the patient is a minor child, the transportation expenses of two companions will be covered and lodging and meal expenses will be reimbursed up to the $100 per diem rate.

There is a combined overall lifetime maximum of $10,000 per Employee or Dependent for all transportation, lodging and meal expenses incurred by the transplant recipient and companion(s) and reimbursed under Plans A, B and C, combined, in connection with all transplant procedures.

Outpatient Alcoholism, Chemical Dependency and Mental Illness Services

Benefits for outpatient services to treat alcoholism, chemical dependency and/or mental illness. The Plan pays 75% of the Covered Expenses in a calendar year after the Deductible is satisfied for the first 40 outpatient visits for alcoholism, chemical dependency and/or mental illness, and then 60% of any additional visits.

Outpatient Rehabilitation

Short-term outpatient rehabilitation services, limited to:

- Physical therapy
- Occupational therapy
- Chiropractic treatment
- Speech therapy
- Pulmonary rehabilitation therapy
- Cardiac rehabilitation therapy

Rehabilitation services are limited to thirty (30) visits per calendar year for any combination of services.

Rehabilitation services must be performed by a Physician or by a licensed therapy provider. Benefits under this section include rehabilitation services provided in a Physician's office or on an outpatient basis at a Hospital.

We will pay benefits for speech therapy for the treatment of disorders of speech, language, voice, communication and auditory processing only when the disorder results from injury, stroke, cancer, congenital anomaly, or autism spectrum disorders.

Physician Services

Physician charges for professional services incurred:

- in a Physician's office;
- during a Hospital confinement;
- for the performance of a surgical operation; or
- in a Skilled Nursing Facility.

When determined to be a Covered Health Service, charges by an assistant surgeon are also covered under the plan.

Preventive Adult Health Services

- One routine physical examination per calendar year, subject to the calendar year Deductible.
- Necessary laboratory tests and/or immunizations, subject to the calendar year Deductible.
- Benefits are available for mammography testing that is consistent with the recommendations of governmental scientific agencies. Benefits for mammography testing are payable when mammography testing is performed as follows:
  - a baseline mammogram; and
  - follow-up mammograms on an annual basis.
- Pap smears are covered annually, or when it is determined by the attending physician that the test is necessary.

The preventive services listed above for mammography testing and pap smears are not subject to coinsurance or the calendar year Deductible.

- Colorectal cancer screenings are covered in compliance with the American Cancer Society colorectal cancer screenings guidelines.
- Prostate cancer screenings are covered in accordance with the latest screening guidelines used by the American Cancer Society.

Preventive Child Health Services

Benefits are available from birth to age 21 including:

- Coverage for injury or sickness, including the necessary care and treatment of medically diagnosed congenital defects, birth abnormalities, and prematurity; and

Coverage for preventive and primary care services, including physician examinations, measurements, sensory screening, neuropsychiatric evaluation, and development screening, which coverage shall include unlimited visits up to the age of 12 years, and 3 visits per year for minor children ages 12 years up to age 21 years of age. Preventive and primary care services shall also include, as recommended by the physician, hereditary and metabolic screening at birth, immunizations, urinalysis, tuberculin tests, and hematocrit, hemoglobin, and other appropriate blood tests, including tests to screen for sickle hemoglobinopathy.

Radiation Therapy

Skilled Nursing Facility

Services and supplies up to [20-60] days of confinement following each Hospital confinement per calendar year.

If charges are made for a private room, Covered Expenses will be limited to the facility's daily charge for a semi-private room.

Skilled nursing facility stays must be approved in advance by Care Coordination in order to be eligible for benefits.

Telehealth

Charges for services provided through telehealth rather than face-to-face consultation when the services can appropriately be provided through telehealth.

- "Telehealth" means the use of live, interactive audio and visual transmissions of a physician-patient encounter from one site to another using telecommunications technologies. They may include transmissions of real-time telecommunications or those transmitted by store-and-forward technology.

- Telemedicine services are medical services provided via ~~telephone, the Internet, or other communications networks or devices~~ interactive audio, video or other electronic media for the purpose of diagnosis, consultation, or treatment that do not involve direct, in-person patient contact.

Treatment Center Services

Charges for services at a Treatment Center when a Physician or Psychologist has certified an alcoholism or chemical dependency and has prescribed such services, up to a calendar year maximum of 60 days. In addition, detoxification services will be covered for up to 12 days annually.

Urgent Care Center Services

Charges for Covered Health Services received at an Urgent Care Center.

X-ray and Laboratory Tests

IMPORTANT: It should be noted that the Covered Expenses listed above do not include charges for drugs, private duty nursing, Physician's home visits, and some other services and supplies which are covered under the ~~Health & Welfare Plan~~Railroad Employees National Health and Welfare Plan, NRC/UTU Plan, GA-46000, the Amtrak Early Retirement Plan, the Keolis Commuter Services (formerly MBCR) Early Retirement Plan, the TransitAmerica Services, Inc. (TASI) Early Retirement Plan or GA-107300.

PREFERRED PROVIDERS

UnitedHealthcare has arranged with certain health care providers to become Preferred Providers. These Preferred Providers have agreed to discount their charges for Covered Expenses.

If Preferred Providers are used, the amount of Covered Expenses for which you are responsible will generally be less than the amount owed if other providers had been used. The percentage of Covered Expenses payable remains the same whether or not Preferred Providers are used. However, because the Covered Expenses may be less when Preferred Providers are used, the portion that you owe will be less.

You will receive an Identification Card showing that you and/or your Dependents Covered under Plans A, B or C, are entitled to these discounts. This Identification Card must be shown every time health care services are given. This is how the provider knows that you and/or your Dependent is covered under a Preferred Provider plan. Otherwise, you could be billed for the provider's normal charge.

Call UnitedHealthcare at 1-800-842-5252 to inquire about or locate Preferred Providers in your area. You may also access Preferred Provider information online at myuhc.com.

Preferred Providers are responsible for filing your claims directly to UnitedHealthcare. You do not need to submit claims for Preferred Providers services or supplies.

You must submit claims for services and supplies rendered by other providers as described in the section entitled Claim Information.

If a Preferred Provider bills you for any part of the discount amount, call UnitedHealthcare at 1-800-842-5252 for assistance.

CARE COORDINATION

Care Coordination is designed to encourage an efficient system of care for you and your Dependent(s) by identifying possible unmet covered health needs. This may include admission counseling, inpatient care advocacy, and certain discharge planning and disease management activities. Care Coordination activities are not a substitute for the medical judgment of your Physician, however, and the ultimate decision as to what medical care you actually receive must be made by you and your Physician.

Care Coordination is triggered when UnitedHealthcare receives notification of an upcoming treatment or service. The notification process serves as a gateway to care coordination activities.

When to Notify Care Coordination

Care Coordination must be notified as soon as possible after you know that you require any of the services or supplies shown below:

- Inpatient admissions to a Hosptial or Skilled Nursing Facility
- Home health care
- Hospice care
- Durable medical equipment (over $1,000)
- Reconstructive procedures
- Dental services rendered as a result of an accident
- [Gender transformation surgery]

With regard to organ/tissue transplants, Care Coordination must be notified at least seven working days before the scheduled date of any of the following or as soon as reasonably possible:

- The evaluation of a transplant
- The donor search
- The organ procurement/tissue harvest
- The transplant procedure

For an in-patient confinement which is the result of an emergency, you (or your representative or Physician) must call Care Coordination within one day (excluding weekends and holidays) from the date the confinement begins.

You should notify Care Coordination promptly after you become aware that you are pregnant. You are required to give this notice, however, only if and when inpatient care for the mother or child is expected to continue beyond:

- 48 hours following a normal delivery; or
- 96 hours following a Caesarean section.

The notice you give must be given in sufficient time to allow UnitedHealthcare to complete a review of the matter before the services are rendered. In the absence of advance notice, UnitedHealthcare may not be able to complete its review and determine, before you incur expenses, if the service is a Covered Health Service, and if so, whether it is Medically Appropriate.

Remember: This notice obligation is your responsibility. It is not the responsibility of your Physician, your Hospital or any other provider.

~~The notification does not apply to injuries incurred by an Employee while on duty for an employing railroad, but UnitedHealthcare customer service representatives are available to answer questions about your proposed medical treatment.~~

How to Give the Required Notice

Notice should be given by telephone at 1-800-842-5252. You can call at any time, day or night. However, if you call outside of the normal hours of operation, you may leave a message with your telephone number on an answering machine, and your call will be returned within one working day.

What Happens After You Give the Required Notice?

UnitedHealthcare will review the services for which you have given notice and will determine whether they are Covered Health Services, and, if so, whether they are Medically Appropriate.

The ultimate decision on your medical care must be made by you and your Physician. Review by Care Coordination only determines whether the service or supply is a Covered Health Service, and if so, whether it is Medically Appropriate, solely for purposes of deciding what, if any, amounts are payable with respect to the service or supply under the Plan.

Effects on Benefits

- Benefits are reduced if you do not give the required notice or if UnitedHealthcare determines that the service or supply, although a Covered Health Services, is not Medically Appropriate. In either case, the benefit will be reduced from [40-60]% to [30-50]% of the benefits payable under the Plan. If you have satisfied your Out-of-Pocket Maximum, benefits will be reduced from 100% to [70-90]%.

- No benefits are payable if UnitedHealthcare determines that the service or supply is not a Covered Health Service.

If UnitedHealthcare determines that a service is not a Covered Health Service or is not Medically Appropriate, you or your Physician can appeal that determination. Please see the Claim Information section for a description of the appeal process.

Case Management Services

UnitedHealthcare also provides case management services. These services focus on severe illnesses and injuries which could result in long-term hospital confinements. UnitedHealthcare will determine whether case management services are appropriate in your case.

Through case management services, benefits for alternative treatment, which are otherwise not Covered Health Services, may be offered to you or your Dependent when it is appropriate and cost effective. The decision to accept alternative treatment rests with the patient and Physician.

Disease Management Services

UnitedHealthcare also provides disease management services. These programs focus on providing information about certain chronic medical conditions, such as heart failure, coronary artery disease, diabetes, or asthma, and the ways these conditions can be treated or managed. If you have been diagnosed with a chronic medical condition, UnitedHealthcare may contact you to discuss this program. Or you may call UnitedHealthcare at 1-800-842-5252 to learn whether you are eligible to participate in a program. Participation is voluntary, and there is no charge for these services.

Through disease management services, benefits for alternative treatment, which are otherwise not Covered Health Services, may be offered to you or your Dependent when it is appropriate and cost effective. The decision to accept alternative treatment rests with the patient and Physician.

Telephonic Access to Nurses and Counselors

UnitedHealthcare provides a toll-free telephone number that puts you in immedicate contact with a registered nurse any time, 24 hours a day, seven days a week. These nurses can provide health information for routine or urgent health concerns, such as a recent diagnosis, a minor sickness or injury, or other health-related topics. You can also listen to pre-recorded messages on a variety of medical topics.

This service is available to you and your Dependents at no charge. To use it, you can call UnitedHealthcare at 1-866-735-5685.

WELLNESS PROGRAMS

Healthy Weight Program

UnitedHealthcare provides a non-surgical approach to addressing weight and obesity through nutritional and activity guidance. You may receive free educational information on the web or through the mail and may even be called by a health coach who is a specialist in weight management. This health coach will be a resource to advise and help you manage your weight.

This program offers:

- on-line self-help tools: health assessment, exercise tracker, meal planner, calorie counter and educational content;
- education on weight management and self-care strategies;
- nutritional guidance and counseling by a health coach and registered dietician (if needed); and
- activity recommendations and encouragement by a health coach and exercise physiologist (if needed).

Participation is completely voluntary and without extra charge. If you would like to participate or would like additional information regarding the program, please call the number on the back of your ID card.

Tobacco Cessation Program

UnitedHealthcare provides a tobacco cessation program to help smokers withdraw from nicotine dependence. By participating in this program, you will receive educational materials through the mail and one-on-one telephone sessions with trained cessation specialists.

This program offers:

- a quit smoking kit that includes a cessation manual and quit aids designed to provide support through this program;
- toll-free telephone access to cessation specialists (you will receive five (5) coaching sessions and may place unlimited calls to the cessation specialists when you have a question); and
- medication recommendations, and/or free over-the-counter nicotine replacement therapies if you or your Dependent are over the age of 18.

Participation is completely voluntary and without extra charge. If you would like to participate or would like additional information regarding the program, please call the number on the back of your ID Card.

Health Assessment

You and your spouse are invited to learn more about your health and wellness at **myuhc.com** and are encouraged to participate in the online health assessment. The health assessment is an interactive questionnaire designed to help you identify your healthy habits as well as potential health risks.

Your health assessment is kept confidential. Completing the assessment will not impact your benefits or eligibility for benefits in any way.

To find the health assessment, log in to **myuhc.com**. After logging in, access your personalized *Health & Wellness* page and click the *Health Assessment* link. If you need any assistance with the online assessment, please call the number on the back of your ID card.

[Next Steps

Individuals that complete a health assessment and are identified with three or more high risk factors, will be provided with telephonic outbound coaching. Coaching will be provided for any/all of the following topics, as appropriate; participation is completely voluntary and without extra charge:

- exercise,
- blood pressure management;
- smoking cessation;
- nutrition;
- stress management;
- cholesterol management; and
- back care/ergonomics.]

V
PLAN B

APPLICABLE TO PERSONS NOT ELIGIBLE UNDER MEDICARE, GA-46000,THE AMTRAK EARLY RETIREMENT MEDICAL PLAN, THE KEOLIS COMMUTER SERVICES (FORMERLY MBCR) EARLY RETIREMENT PLAN, OR THE TRANSITAMERICA SERVICES, INC. (TASI) EARLY RETIREMENT PLAN

MAJOR MEDICAL EXPENSE BENEFITS

The Plan pays a percentage of Covered Expenses incurred in a calendar year which exceed the Deductible.

DEDUCTIBLE

The Deductible amount is [$500 - $3,000]. It applies separately to each covered individual each calendar year.

PERCENTAGE OF COVERED EXPENSES PAYABLE

The Plan pays [50% - 70%] (75% for the first 40 outpatient visits for alcoholism, chemical dependency and/or mental illness, and 60% for any visits thereafter) of the Covered Expenses in a calendar year after the Deductible is satisfied.

The Plan pays [30-50]% of the Covered Expenses in a calendar year after the Deductible is satisfied when Care Coordination is not called when required. See the Care Coordination description contained in this Section V.

The Plan pays 100% of Covered Expenses in a calendar year after the Out-of-Pocket Maximum is met. ([70-90]% if Care Coordination is not called when required.)

OUT-OF-POCKET MAXIMUM

The Out-of-Pocket Maximum limits the amount of Covered Expenses you will have to pay for any one covered individual in a calendar year. The Out-of-Pocket Maximum is [$5,000 - $30,000] each calendar year. Covered Expenses used to satisfy your Deductible are also used to help satisfy your Out-of-Pocket Maximum.

The following expenses do not count in determining if any Out-of-Pocket Maximum has been met:

- Charges you pay that are in excess of the Reasonable Charge.
- Charges you pay that are in excess of specific Plan limits or exclusions.
- Charges you pay for expenses not covered by the Plan.
- [Charges you pay as a result of the reduction in benefits payable when Care Coordination is not notified or if the service or supply, although a Covered Health Service, is not Medically Appropriate.]

MAXIMUM AMOUNT

The Maximum Amount payable with respect to you or any of your Dependents is [$200,000 - unlimited]. The Maximum Amount applies to a person's entire lifetime and is a combined lifetime maximum under Plans A, B and C.

The Maximum Amount for anyone who has received benefits will be restored each January 1 by $1,000, or lesser amount, until the maximum is again [$200,000 - unlimited].

COVERED EXPENSES

Covered Expenses are the actual cost to you of the Reasonable Charges (see Definitions) for Covered Health Services (see Definitions) and supplies listed below. The service or supply must be needed because of injury, sickness or pregnancy.

A service or supply is not a Covered Health Service just because it is furnished by, or ordered by, your provider. The services and supplies will be reviewed by UnitedHealthcare to determine if they are considered Covered Health Services.

Acupuncture Services

Acupuncture services for the following conditions:

- Pain therapy, when another method of pain management has failed.
- Nausea that is related to surgery, pregnancy or chemotherapy.

Acupuncture services must be performed in an office setting by a provider who is one of the following, either practicing within the scope of his/her license (if state license is available) or who is certified by a national accrediting body:

- Doctor of Medicine
- Doctor of Osteopathy
- Acupuncturist
- Chiropractor
- Physician's Assistant

Allergy Immunotherapy Received in a Physician's Office

Benefits are available for allergy immunotherapy received in a Physician's office.

Ambulatory Surgical Center

Charges for services and supplies furnished in an Ambulatory Surgical Center in connection with a surgical procedure within 24 hours from and in connection with the surgical procedure.

Anesthetics

Applied Behavioral Analysis Services

Applied Behavioral Analysis (ABA) services for Autism Spectrum Disorders that are:

- Focused on the treatment of core deficits of Autism Spectrum Disorder;
- Provided by a *Board Certified Applied Behavioral Analyst (BCBA)* or other qualified provider under the appropriate supervision; and
- Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property, and impairment in daily functioning.
- Services include the following:
- Diagnostic evaluations, assessment and treatment planning.
- Treatment and/or procedures.
- Medication management and other associated treatments.
- Individual, family, and group therapy.
- Provider-based case management services.
- Crisis intervention.

[Assistant Surgeon

Coverage for assistant surgeon services are limited to 1/5 of the amount of the Reasonable Charge for the surgeon's charge for the surgery. An assistant surgeon must be a Physician. Surgical assistant's services are covered at the same or lesser rate.]

Chemotherapy

Clinical Trials

Routine patient care costs incurred during participation in an approved clinical trial meeting the approved clinical trial criteria stated below.

Benefits include the reasonable and necessary items and services used to diagnose and treat complications arising from participation in an approved clinical trial.

Benefits are available only when the Covered Family Member is clinically eligible for participation in the clinical trial as defined by the researcher. Benefits are not available for preventive clinical trials.

Routine patient care costs for clinical trials include:

- Covered Health Services for which benefits are typically provided absent a clinical trial.
- Covered Health Services required solely for the provision of the investigational item or service, the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications.
- Covered Health Services needed for reasonable and necessary care arising from the provision of an investigational item or service.

Routine costs for clinical trials do not include:

- The Experimental or Investigational Service or item. The only exceptions to this are:
  - Certain Category B devices.
  - Certain promising interventions for patients with terminal illnesses.
  - Other items and services that meet specified criteria in accordance with our medical policy guidelines.
- Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.
- Items and services provided by the research sponsors free of charge for any person enrolled in the trial.

To be an approved clinical trial, a clinical trial must meet all of the following criteria:

- Be approved and funded in full or in part by one or more of the following:
  - National Institutes of Health (NIH). (Includes National Cancer Institute (NCI).)
  - Centers for Disease Control and Prevention (CDC).
  - Agency for Healthcare Research and Quality (AHRQ).
  - Centers for Medicare and Medicaid Services (CMS).
  - A bona fide clinical trial cooperative group, including the National Cancer Institute Clinical Trials Cooperative Group, the National Cancer Institute Community Clinical Oncology Program, the AIDS Clinical Trials Group, and the Community Programs for Clinical Research in AIDS.
  - The Department of Defense (DOD), the Department of Veterans Affairs, or the Department of Energy, or a qualified nongovernmental research entity to which the National Cancer Institute has awarded a support grant.
  - A study or investigation approved by the Food and Drug Administration (FDA), including those conducted under an investigational new drug or device application reviewed by the FDA.
  - An investigation or study approved by an Institutional Review Board registered with the Department of Health and Human Services that is associated with an institution that has a federal-wide assurance approved by the Department of Health and Human Services specifying compliance with federal regulations.
- The clinical trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (IRBs) before participants are enrolled in the trial. We may, at any time, request documentation about the trial to confirm that the clinical trial meets current standards for scientific merit and has the relevant IRB approvals.

The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Service and is not otherwise excluded under the Policy.

Convenient Care Clinic

Diabetes Treatment

Coverage for diabetic equipment, diabetes supplies and in-person outpatient diabetic self-management training and education programs (including medical nutrition therapy) when provided under the direction of a Physician by a certified, registered or licensed health care professional.

Diabetes self-management training includes training provided to a Covered Person after the initial diagnosis in the care and management of that condition, including nutritional counseling and proper use of diabetes equipment and supplies. Coverage is also provided for additional training upon diagnosis of a significant change in medical condition that requires a change in the self-management regime, and a periodic continuing education training as warranted by the development of new techniques and treatment for diabetes.

Durable Medical Equipment

Durable Medical Equipment that meets each of the following criteria:

- Ordered or provided by a Physician for outpatient use primarily in a home setting.
- Used for medical purposes.
- Not consumable or disposable except as needed for the effective use of covered Durable Medical Equipment.
- Not of use to a person in the absence of a disease or disability.

Examples of Durable Medical Equipment include:

- Equipment to assist mobility, such as a standard wheelchair.
- A standard Hospital-type bed. Non-hospital beds, comfort beds, and motorized beds/mattresses are generally excluded from coverage.
- Oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks).
- Delivery pumps for tube feedings (including tubing and connectors).
- Braces, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are considered Durable Medical Equipment and are a Covered Health Service. Braces that straighten or change the shape of a body part are orthotic devices, and are excluded from coverage. Dental braces are also excluded from coverage.
- Mechanical equipment necessary for the treatment of chronic or acute respiratory failure (air-conditioners, humidifiers, dehumidifiers, air purifiers and filters, and personal comfort items are excluded from coverage).
- Burn garments.
- Insulin pumps and all related necessary supplies.
- Wigs, but only for loss of hair resulting from treatment of a malignancy or permanent loss of hair from an accidental injury, and up to a maximum of [$500 per calendar year].
- Speech aid prosthetics and traceo-esophaeal voice prosthetics. All other devices and computers to assist in communication and speech are not considered Durable Medical Equipment.
- External prosthetic devices that replace a limb or body part.

Benefits under this section do not include:

- Durable Medical Equipment provided to you by a Physician.
- Generally, any device, appliance, pump, machine stimulator, or monitor that is fully implanted into the body.

If you have any questions regarding whether a particular item is considered to be Durable Medical Equipment, please contact Care Coordination.

Care Coordination must be contacted for any purchase or rental of Durable Medical Equipment that exceeds [$1,000]. UnitedHealthcare will decide if the equipment should be purchased or rented.

Benefits that are available for repairs and replacement, except that:

- Benefits for repair and replacement do not apply to damage due to misuse, malicious breakage or gross neglect.
- Benefits are not available to replace lost or stolen items.
- Replacement of Durable Medical Equipment is limited to every three years, unless there are catastrophic circumstances, in which case you should notify UnitedHealthcare and an individual case evaluation will be performed.

If more than one piece of Durable Medical Equipment can meet your functional needs, benefits are available only for the equipment that meets the minimum specifications for your needs. If you rent or purchase a piece of Durable Medical Equipment that exceeds this guideline, you will be responsible for any cost difference between the piece you rent or purchase and the piece that UnitedHealthcare has determined is the most cost-effective.

Emergency Transportation Services

Transportation charges are covered for transportation to a Hospital in connection with an emergency.

The transportation services must be to a Hospital in your local area. If there are no local Hospitals that can provide the care needed, charges for transportation to the nearest Hospital outside your local area qualified to give the required treatment, will be covered.

Habilitative Services

Habilitative Services for children from birth to age 21 are covered, except for Habilitative Services provided in early intervention and school services.

Habilitative Services includes services, including occupational therapy, physical therapy, and speech therapy, for the treatment of a child with a congenital or genetic birth defect to enhance the child's ability to function. For purposes of Habilitaitive Services, a cogenital or genetic birth defect means a defect existing at or from birth, including a hereditary defect. A congential or genetic birth defect includes, but is not limited to (a) autism or autism spectrum disorder, and (b) cerebral palsy.

Home Health Care Agency Services

Charges for services of a Home Health Care Agency prescribed in writing by a Physician to be in lieu of Hospital confinement, up to a maximum of 30 visits during any one calendar year. Each visit by a member of a home health care team will be considered as one home health care visit. Four hours of home health care services will be considered as one home health care visit. If a visit exceeds four hours, each additional four hours, or part thereof, will count as one additional visit. Each visit by any other member of the home health care team will count as an additional visit.

The following services and supplies of a Home Health Care Agency are covered:

- Temporary or part-time nursing care by or supervised by a registered graduate nurse (R.N.).
- Temporary or part-time care by a home health aide.
- Physical therapy, occupational therapy or speech therapy.
- Medical supplies.
- Drugs and medications ordered by a Physician.
- X-ray and laboratory tests.

Hospice

Hospice care that is recommended by a Physician, for a period of up to six (6) months. Hospice care is an integrated program that provides comfort and support services for the terminally ill. Hospice care includes physical, psychological, social and spiritual care for the terminally ill person and short-term grief counseling for immediate family members while the patient is receiving hospice care.

You must notify and receive approval from Care Coordination prior to receiving any inpatient or outpatient hospice care in order to be eligible for this benefit.

Benefits are available when hospice care is received from a licensed hospice agency.

A Physician must certify that the patient is terminally ill and that the patient's life expectancy is six (6) months or less.

Hospital Services

Services and supplies provided by a Hospital on an inpatient basis, except that if charges are made for a private room, Covered Expenses will be limited to the hospital's average daily charge for a semi-private room.

Coverage is provided for up to 60 inpatient days per calendar year for alcoholism, chemical dependency and/or mental illness services. In addition, coverage is provided for up to 12 days per calendar year for inpatient detoxification services.

Coverage is also provided for newborn infant hearing screenings and all necessary audiological examinations provided as recommended by the national Joint Committee on Infant Hearing. For purposes of this coverage, "Hospital" shall include birthing centers or other centers having newborn nurseries.

Services and supplies provided by a Hospital on an outpatient basis including:

- Emergency care and treatment for a medical emergency, including the sudden onset or worsening of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent lay person, who possesses an average knowledge of health and medicine to result in:
  - Placing the patient's health in serious jeopardy;
  - Serious impairment to bodily functions; or
  - Serious dsyfunction of any bodily organ or part.
- Voluntary HIV screening test performed while receiving emergency care in a Hospital, once per calendar year, regardless of whether or not the HIV screeming in necessary for the treatment of the condition for which the emergency care is sought..

Medical Supplies

- Medical and surgical supplies (such as bandages and dressings). Supplies given during surgery or a diagnostic procedure are included in the overall cost for that surgery or diagnostic procedure.
- Blood or blood derivatives only if not donated or replaced.

Multiple Surgical Procedures

When more than one surgical procedure is performed during the same operative session, Covered Expenses are limited as follows:

- Covered Expenses for the second procedure will be limited to 50% of the Reasonable Charge for that procedure had it been performed alone.
- Covered Expenses for any subsequent procedure are limited to 50% of the Reasonable Charge for the subsequent procedures.

Organ/Tissue Transplants

- Donor Charges

  In the case of an organ or tissue transplant, no services or supplies for the donor are considered Covered Health Services unless the recipient is the Employee or his/her Dependent. If the recipient is not the Employee or his/her Dependent, no benefits are payable for donor charges.

  The search for bone marrow/stem cell from a donor who is not biologically related to the patient is not considered a Covered Health Service UNLESS the search is made in connection with a transplant procedure arranged by a Transplant Facility.

- Qualified Procedures

  If a qualified procedure, listed below, is Medically Appropriate and performed at a Transplant Facility, the "Medical Care and Treatment" and "Transportation and Lodging" provisions set forth below apply:

    - Heart transplants
    - Heart/lung transplants
    - Liver transplants
    - Kidney transplants
    - Pancreas transplants
    - Kidney/pancreas transplants
    - Bone marrow/stem cell transplants
    - Other transplant procedures when UnitedHealthcare determines that it is necessary to perform the procedure at a Treatment Facility.

  If a transplant, even if determined to be Medically Appropriate, is not performed at a Transplant Facility, there will be no benefit payable for the "Medical Care and Treatment" or the "Transportation and Lodging" provisions set forth below.

- Medical Care and Treatment
  - The following services provided in connection with the transplant are Covered Health Services:
    - Pre-transplant evaluation for one of the procedures listed above
    - Organ acquisition and procurement
    - Hospital and Physician fees
    - Transplant procedures
    - Follow-up care for a period up to one year after the transplant
    - Search for bone marrow/stem cell from a donor who is not biologically related to the patient. If a separate charge is made for a bone marrow/stem cell search, a maximum benefit of $25,000 is payable for all charges made in connection with the search.

- Transportation and Lodging

  Care Coordination will assist the patient and family with travel and lodging arrangements. Expenses for travel, lodging and meals for the transplant recipient and a companion are available under this Plan as follows:

  - Reasonable and necessary expenses for transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of the transplant for the purposes of an evaluation, the transplant procedure or necessary post-discharge follow-up.
  - Reasonable and necessary expenses for lodging and meals for the patient (while not confined) and one companion. Benefits are paid at a per diem rate of up to $50 for one person or up to $100 for two people.

  Travel and lodging expenses are only available if the transplant recipient resides more than 50 miles from the Transplant Facility.

  If the Dependent who is the patient is a minor child, the transportation expenses of two companions will be covered and lodging and meal expenses will be reimbursed up to the $100 per diem rate.

There is a combined overall lifetime maximum of $10,000 per Employee or Dependent for all transportation, lodging and meal expenses incurred by the transplant recipient and companion(s) and reimbursed under Plans A, B and C, combined, in connection with all transplant procedures.

Outpatient Alcoholism, Chemical Dependency and Mental Illness Services

Benefits for outpatient services to treat alcoholism, chemical dependency and/or mental illness. The Plan pays 75% of the Covered Expenses in a calendar year after the Deductible is satisfied for the first 40 outpatient visits for alcoholism, chemical dependency and/or mental illness, and then 60% of any additional visits.

Outpatient Rehabilitation

Short-term outpatient rehabilitation services, limited to:

- Physical therapy
- Occupational therapy
- Chiropractic treatment
- Speech therapy
- Pulmonary rehabilitation therapy
- Cardiac rehabilitation therapy

Rehabilitation services are limited to thirty (30) visits per calendar year for any combination of services.

Rehabilitation services must be performed by a Physician or by a licensed therapy provider. Benefits under this section include rehabilitation services provided in a Physician's office or on an outpatient basis at a Hospital.

We will pay benefits for speech therapy for the treatment of disorders of speech, language, voice, communication and auditory processing only when the disorder results from injury, stroke, cancer, congenital anomaly, or autism spectrum disorders.

Physician Services

Physician charges for professional services incurred:

- in a Physician's office;
- during a Hospital confinement;
- for the performance of a surgical operation; or
- in a Skilled Nursing Facility.

When determined to be a Covered Health Service, charges by an assistant surgeon are also covered under the plan.

Preventive Adult Health Services

- One routine physical examination per calendar year, subject to the calendar year Deductible.
- Necessary laboratory tests and/or immunizations, subject to the calendar year Deductible.
- Benefits are available for mammography testing that is consistent with the recommendations of governmental scientific agencies. Benefits for mammography testing are payable when mammography testing is performed as follows:
  - a baseline mammogram; and
  - follow-up mammograms on an annual basis.
- Pap smears are covered annually, or when it is determined by the attending physician that the test is necessary.

The preventive services listed above for mammography testing and pap smears are not subject to coinsurance or the calendar year Deductible.

- Colorectal cancer screenings are covered in compliance with the American Cancer Society colorectal cancer screenings guidelines.
- Prostate cancer screenings are covered in accordance with the latest screening guidelines used by the American Cancer Society.

Preventive Child Health Services

Benefits are available from birth to age 21 including:

- Coverage for injury or sickness, including the necessary care and treatment of medically diagnosed congenital defects, birth abnormalities, and prematurity; and

Coverage for preventive and primary care services, including physician examinations, measurements, sensory screening, neuropsychiatric evaluation, and development screening, which coverage shall include unlimited visits up to the age of 12 years, and 3 visits per year for minor children ages 12 years up to age 21 years of age. Preventive and primary care services shall also include, as recommended by the physician, hereditary and metabolic screening at birth, immunizations, urinalysis, tuberculin tests, and hematocrit, hemoglobin, and other appropriate blood tests, including tests to screen for sickle hemoglobinopathy.

Radiation Therapy

Skilled Nursing Facility

Services and supplies up to [20-60] days of confinement following each Hospital confinement per calendar year.

If charges are made for a private room, Covered Expenses will be limited to the facility's daily charge for a semi-private room.

Skilled nursing facility stays must be approved in advance by Care Coordination in order to be eligible for benefits.

Telehealth

Charges for services provided through telehealth rather than face-to-face consultation when the services can appropriately be provided through telehealth.

- "Telehealth" means the use of live, interactive audio and visual transmissions of a physician-patient encounter from one site to another using telecommunications technologies. They may include transmissions of real-time telecommunications or those transmitted by store-and-forward technology.

- Telemedicine services are medical services provided via ~~telephone, the Internet, or other communications networks or devices~~ interactive audio, video or other electronic media for the purpose of diagnosis, consultation, or treatment that do not involve direct, in-person patient contact.

Treatment Center Services

Charges for services at a Treatment Center when a Physician or Psychologist has certified an alcoholism or chemical dependency and has prescribed such services, up to a calendar year maximum of 60 days. In addition, detoxification services will be covered for up to 12 days annually.

Urgent Care Center Services

Charges for Covered Health Services received at an Urgent Care Center.

X-ray and Laboratory Tests

IMPORTANT: It should be noted that the Covered Expenses listed above do not include charges for drugs, private duty nursing, Physician's home visits, and some other services and supplies which are covered under the ~~Health & Welfare Plan~~Railroad Employees National Health and Welfare Plan, NRC/UTU Plan, GA-46000, the Amtrak Early Retirement Plan, the Keolis Commuter Services (formerly MBCR) Early Retirement Plan, the TransitAmerica Services, Inc. (TASI) Early Retirement Plan or GA-107300.

PREFERRED PROVIDERS

UnitedHealthcare has arranged with certain health care providers to become Preferred Providers. These Preferred Providers have agreed to discount their charges for Covered Expenses.

If Preferred Providers are used, the amount of Covered Expenses for which you are responsible will generally be less than the amount owed if other providers had been used. The percentage of Covered Expenses payable remains the same whether or not Preferred Providers are used. However, because the Covered Expenses may be less when Preferred Providers are used, the portion that you owe will be less.

You will receive an Identification Card showing that you and/or your Dependents Covered under Plans A, B or C, are entitled to these discounts. This Identification Card must be shown every time health care services are given. This is how the provider knows that you and/or your Dependent is covered under a Preferred Provider plan. Otherwise, you could be billed for the provider's normal charge.

Call UnitedHealthcare at 1-800-842-5252 to inquire about or locate Preferred Providers in your area. You may also access Preferred Provider information online at myuhc.com.

Preferred Providers are responsible for filing your claims directly to UnitedHealthcare. You do not need to submit claims for Preferred Providers services or supplies.

You must submit claims for services and supplies rendered by other providers as described in the section entitled Claim Information.

If a Preferred Provider bills you for any part of the discount amount, call UnitedHealthcare at 1-800-842-5252 for assistance.

CARE COORDINATION

Care Coordination is designed to encourage an efficient system of care for you and your Dependent(s) by identifying possible unmet covered health needs. This may include admission counseling, inpatient care advocacy, and certain discharge planning and disease management activities. Care Coordination activities are not a substitute for the medical judgment of your Physician, however, and the ultimate decision as to what medical care you actually receive must be made by you and your Physician.

Care Coordination is triggered when UnitedHealthcare receives notification of an upcoming treatment or service. The notification process serves as a gateway to care coordination activities.

When to Notify Care Coordination

Care Coordination must be notified as soon as possible after you know that you require any of the services or supplies shown below:

- Inpatient admissions to a Hosptial or Skilled Nursing Facility
- Home health care
- Hospice care
- Durable medical equipment (over $1,000)
- Reconstructive procedures
- Dental services rendered as a result of an accident
- [Gender transformation surgery]

With regard to organ/tissue transplants, Care Coordination must be notified at least seven working days before the scheduled date of any of the following or as soon as reasonably possible:

- The evaluation of a transplant
- The donor search
- The organ procurement/tissue harvest
- The transplant procedure

For an in-patient confinement which is the result of an emergency, you (or your representative or Physician) must call Care Coordination within one day (excluding weekends and holidays) from the date the confinement begins.

You should notify Care Coordination promptly after you become aware that you are pregnant. You are required to give this notice, however, only if and when inpatient care for the mother or child is expected to continue beyond:

- 48 hours following a normal delivery; or
- 96 hours following a Caesarean section.

The notice you give must be given in sufficient time to allow UnitedHealthcare to complete a review of the matter before the services are rendered. In the absence of advance notice, UnitedHealthcare may not be able to complete its review and determine, before you incur expenses, if the service is a Covered Health Service, and if so, whether it is Medically Appropriate.

Remember: This notice obligation is your responsibility. It is not the responsibility of your Physician, your Hospital or any other provider.

~~The notification does not apply to injuries incurred by an Employee while on duty for an employing railroad, but UnitedHealthcare customer service representatives are available to answer questions about your proposed medical treatment.~~

How to Give the Required Notice

Notice should be given by telephone at 1-800-842-5252. You can call at any time, day or night. However, if you call outside of the normal hours of operation, you may leave a message with your telephone number on an answering machine, and your call will be returned within one working day.

What Happens After You Give the Required Notice?

UnitedHealthcare will review the services for which you have given notice and will determine whether they are Covered Health Services, and, if so, whether they are Medically Appropriate.

The ultimate decision on your medical care must be made by you and your Physician. Review by Care Coordination only determines whether the service or supply is a Covered Health Service, and if so, whether it is Medically Appropriate, solely for purposes of deciding what, if any, amounts are payable with respect to the service or supply under the Plan.

Effects on Benefits

- Benefits are reduced if you do not give the required notice or if UnitedHealthcare determines that the service or supply, although a Covered Health Services, is not Medically Appropriate. In either case, the benefit will be reduced from [60-80]% to [40-60]% of the benefits payable under the Plan. If you have satisfied your Out-of-Pocket Maximum, benefits will be reduced from 100% to [70-90]%.

- No benefits are payable if UnitedHealthcare determines that the service or supply is not a Covered Health Service.

If UnitedHealthcare determines that a service is not a Covered Health Service or is not Medically Appropriate, you or your Physician can appeal that determination. Please see the Claims Information section for a description of the appeal process.

Case Management Services

UnitedHealthcare also provides case management services. These services focus on severe illnesses and injuries which could result in long-term hospital confinements. UnitedHealthcare will determine whether case management services are appropriate in your case.

Through case management services, benefits for alternative treatment, which are otherwise not Covered Health Services, may be offered to you or your Dependent when it is appropriate and cost effective. The decision to accept alternative treatment rests with the patient and Physician.

Disease Management Services

UnitedHealthcare also provides disease management services. These programs focus on providing information about certain chronic medical conditions, such as heart failure, coronary artery disease, diabetes, or asthma, and the ways these conditions can be treated or managed. If you have been diagnosed with a chronic medical condition, UnitedHealthcare may contact you to discuss this program. Or you may call UnitedHealthcare at 1-800-842-5252 to learn whether you are eligible to participate in a program. Participation is voluntary, and there is no charge for these services.

Through disease management services, benefits for alternative treatment, which are otherwise not Covered Health Services, may be offered to you or your Dependent when it is appropriate and cost effective. The decision to accept alternative treatment rests with the patient and Physician.

Telephonic Access to Nurses and Counselors

UnitedHealthcare provides a toll-free telephone number that puts you in immedicate contact with a registered nurse any time, 24 hours a day, seven days a week. These nurses can provide health information for routine or urgent health concerns, such as a recent diagnosis, a minor sickness or injury, or other health-related topics. You can also listen to pre-recorded messages on a variety of medical topics.

This service is available to you and your Dependents at no charge. To use it, you can call UnitedHealthcare at 1-866-735-5685.

WELLNESS PROGRAMS

Healthy Weight Program

UnitedHealthcare provides a non-surgical approach to addressing weight and obesity through nutritional and activity guidance. You may receive free educational information on the web or through the mail and may even be called by a health coach who is a specialist in weight management. This health coach will be a resource to advise and help you manage your weight.

This program offers:

- on-line self-help tools: health assessment, exercise tracker, meal planner, calorie counter and educational content;
- education on weight management and self-care strategies;
- nutritional guidance and counseling by a health coach and registered dietician (if needed); and
- activity recommendations and encouragement by a health coach and exercise physiologist (if needed).

Participation is completely voluntary and without extra charge. If you would like to participate or would like additional information regarding the program, please call the number on the back of your ID card.

Tobacco Cessation Program

UnitedHealthcare provides a tobacco cessation program to help smokers withdraw from nicotine dependence. By participating in this program, you will receive educational material through the mail and one on one telephone sessions with trained cessation specialists.

This program offers:

- a quit smoking kit that includes a cessation manual and quit aids designed to provide support through this program;
- toll-free telephone access to cessation specialists (you will receive five (5) coaching sessions and may place unlimited calls to the cessation specialists when you have a question); and
- medication recommendations, and/or free over-the-counter nicotine replacement therapies if you or your Dependent is over the age of 18.

Participation is completely voluntary and without extra charge. If you would like to participate or would like additional information regarding the program, please call the number on the back of your ID Card.

Health Assessment

You and your spouse are invited to learn more about your health and wellness at **myuhc.com** and are encouraged to participate in the online health assessment. The health assessment is an interactive questionnaire designed to help you identify your healthy habits as well as potential health risks.

Your health assessment is kept confidential. Completing the assessment will not impact your benefits or eligibility for benefits in any way.

To find the health assessment, log in to **myuhc.com**. After logging in, access your personalized *Health & Wellness* page and click the *Health Assessment* link. If you need any assistance with the online assessment, please call the number on the back of your ID card.

[Next Steps

Individuals that complete a health assessment and are identified with three or more high risk factors, will be provided with telephonic outbound coaching. Coaching will be provided for any/all of the following topics, as appropriate; participation is completely voluntary and without extra charge:

- exercise,
- blood pressure management;
- smoking cessation;
- nutrition;
- stress management;
- cholesterol management; and
- back care/ergonomics.]

VI
PLAN C

APPLICABLE TO PERSONS NOT ELIGIBLE UNDER MEDICARE, GA-46000 THE AMTRAK EARLY RETIREMENT MEDICAL PLAN, THE KEOLIS COMMUTER SERVICES (FORMERLY MBCR) EARLY RETIREMENT PLAN, THE TRANSITAMERICA SERVICES, INC. (TASI) EARLY RETIREMENT PLAN

MAJOR MEDICAL EXPENSE BENEFITS

The Plan pays a percentage of Covered Expenses incurred in a calendar year which exceed the Deductible.

DEDUCTIBLE

The Deductible amount is [$500 - $3,000]. It applies separately to each covered individual each calendar year.

PERCENTAGE OF COVERED EXPENSES PAYABLE

The Plan pays [60% - 80%] (75% for the first 40 outpatient visits for alcoholism, chemical dependency and/or mental illness, and 60% for any visits thereafter) of the Covered Expenses in a calendar year after the Deductible is satisfied.

The Plan pays [40-60]% of the Covered Expenses in a calendar year after the Deductible is satisfied when Care Coordination is not called when required. See the Care Coordination description contained in this Section VI.

The Plan pays 100% of Covered Expenses in a calendar year after the Out-of-Pocket Maximum is met. ([70-90]% if Care Coordination is not called when required.)

OUT-OF-POCKET MAXIMUM

The Out-of-Pocket Maximum limits the amount of Covered Expenses you will have to pay for any one covered individual in a calendar year. The Out-of-Pocket Maximum is [$5,000 - $30,000] each calendar year. Covered Expenses used to satisfy your Deductible are also used to help satisfy your Out-of-Pocket Maximum.

The following expenses do not count in determining if any Out-of-Pocket Maximum has been met:

- Charges you pay that are in excess of the Reasonable Charge.
- Charges you pay that are in excess of specific Plan limits or exclusions.
- Charges you pay for expenses not covered by the Plan.
- [Charges you pay as a result of the reduction in benefits payable when Care Coordination is not notified or if the service or supply, although a Covered Health Service, is not Medically Appropriate.]

MAXIMUM AMOUNT

The Maximum Amount payable with respect to you or any of your Dependents is [$200,000 - unlimited]. The Maximum Amount applies to a person's entire lifetime and is a combined lifetime maximum under Plans A, B and C.

The Maximum Amount for anyone who has received benefits will be restored each January 1 by $1,000, or lesser amount, until the maximum is again [$200,000 - unlimited].

COVERED EXPENSES

Covered Expenses are the actual cost to you of the Reasonable Charges (see Definitions) for Covered Health Services (see Definitions) and supplies listed below. The service or supply must be needed because of injury, sickness or pregnancy.

A service or supply is not a Covered Health Service just because it is furnished by, or ordered by, your provider. The services and supplies will be reviewed by UnitedHealthcare to determine if they are considered Covered Health Services.

Acupuncture Services

Acupuncture services for the following conditions:

- Pain therapy, when another method of pain management has failed.
- Nausea that is related to surgery, pregnancy or chemotherapy.

Acupuncture services must be performed in an office setting by a provider who is one of the following, either practicing within the scope of his/her license (if state license is available) or who is certified by a national accrediting body:

- Doctor of Medicine
- Doctor of Osteopathy
- Acupuncturist
- Chiropractor
- Physician's Assistant

Allergy Immunotherapy Received in a Physician's Office

Benefits are available for allergy immunotherapy received in a Physician's office.

Ambulatory Surgical Center

Charges for services and supplies furnished in an Ambulatory Surgical Center in connection with a surgical procedure within 24 hours from and in connection with the surgical procedure.

Anesthetics

Applied Behavioral Analysis Services

Applied Behavioral Analysis (ABA) services for Autism Spectrum Disorders that are:

- Focused on the treatment of core deficits of Autism Spectrum Disorder;
- Provided by a *Board Certified Applied Behavioral Analyst (BCBA)* or other qualified provider under the appropriate supervision; and
- Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property, and impairment in daily functioning.
- Services include the following:
- Diagnostic evaluations, assessment and treatment planning.
- Treatment and/or procedures.
- Medication management and other associated treatments.
- Individual, family, and group therapy.
- Provider-based case management services.
- Crisis intervention.

[Assistant Surgeon

Coverage for assistant surgeon services are limited to 1/5 of the amount of the Reasonable Charge for the surgeon's charge for the surgery. An assistant surgeon must be a Physician. Surgical assistant's services are covered at the same or lesser rate.]

Chemotherapy

Clinical Trials

Routine patient care costs incurred during participation in an approved clinical trial meeting the approved clinical trial criteria stated below.

Benefits include the reasonable and necessary items and services used to diagnose and treat complications arising from participation in an approved clinical trial.

Benefits are available only when the Covered Family Member is clinically eligible for participation in the clinical trial as defined by the researcher. Benefits are not available for preventive clinical trials.

Routine patient care costs for clinical trials include:

- Covered Health Services for which benefits are typically provided absent a clinical trial.
- Covered Health Services required solely for the provision of the investigational item or service, the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications.
- Covered Health Services needed for reasonable and necessary care arising from the provision of an investigational item or service.

Routine costs for clinical trials do not include:

- The Experimental or Investigational Service or item. The only exceptions to this are:
  - Certain Category B devices.
  - Certain promising interventions for patients with terminal illnesses.
  - Other items and services that meet specified criteria in accordance with our medical policy guidelines.
- Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.
- Items and services provided by the research sponsors free of charge for any person enrolled in the trial.

To be an approved clinical trial, a clinical trial must meet all of the following criteria:

- Be approved and funded in full or in part by one or more of the following:
  - National Institutes of Health (NIH). (Includes National Cancer Institute (NCI).)
  - Centers for Disease Control and Prevention (CDC).
  - Agency for Healthcare Research and Quality (AHRQ).
  - Centers for Medicare and Medicaid Services (CMS).
  - A bona fide clinical trial cooperative group, including the National Cancer Institute Clinical Trials Cooperative Group, the National Cancer Institute Community Clinical Oncology Program, the AIDS Clinical Trials Group, and the Community Programs for Clinical Research in AIDS.
  - The Department of Defense (DOD), the Department of Veterans Affairs, or the Department of Energy, or a qualified nongovernmental research entity to which the National Cancer Institute has awarded a support grant.
  - A study or investigation approved by the Food and Drug Administration (FDA), including those conducted under an investigational new drug or device application reviewed by the FDA.
  - An investigation or study approved by an Institutional Review Board registered with the Department of Health and Human Services that is associated with an institution that has a federal-wide assurance approved by the Department of Health and Human Services specifying compliance with federal regulations.
- The clinical trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (IRBs) before participants are enrolled in the trial. We may, at any time, request documentation about the trial to confirm that the clinical trial meets current standards for scientific merit and has the relevant IRB approvals.

The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Service and is not otherwise excluded under the Policy.

Convenient Care Clinic

Diabetes Treatment

Coverage for diabetic equipment, diabetes supplies and in-person outpatient diabetic self-management training and education programs (including medical nutrition therapy) when provided under the direction of a Physician by a certified, registered or licensed health care professional.

Diabetes self-management training includes training provided to a Covered Person after the initial diagnosis in the care and management of that condition, including nutritional counseling and proper use of diabetes equipment and supplies. Coverage is also provided for additional training upon diagnosis of a significant change in medical condition that requires a change in the self-management regime, and a periodic continuing education training as warranted by the development of new techniques and treatment for diabetes.

Durable Medical Equipment

Durable Medical Equipment that meets each of the following criteria:

- Ordered or provided by a Physician for outpatient use primarily in a home setting.
- Used for medical purposes.
- Not consumable or disposable except as needed for the effective use of covered Durable Medical Equipment.
- Not of use to a person in the absence of a disease or disability.

Examples of Durable Medical Equipment include:

- Equipment to assist mobility, such as a standard wheelchair.
- A standard Hospital-type bed. Non-hospital beds, comfort beds, and motorized beds/mattresses are generally excluded from coverage.
- Oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks).
- Delivery pumps for tube feedings (including tubing and connectors).
- Braces, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are considered Durable Medical Equipment and are a Covered Health Service. Braces that straighten or change the shape of a body part are orthotic devices, and are excluded from coverage. Dental braces are also excluded from coverage.
- Mechanical equipment necessary for the treatment of chronic or acute respiratory failure (air-conditioners, humidifiers, dehumidifiers, air purifiers and filters, and personal comfort items are excluded from coverage).
- Burn garments.
- Insulin pumps and all related necessary supplies.
- Wigs, but only for loss of hair resulting from treatment of a malignancy or permanent loss of hair from an accidental injury, and up to a maximum of [$500 per calendar year].
- Speech aid prosthetics and traceo-esophaeal voice prosthetics. All other devices and computers to assist in communication and speech are not considered Durable Medical Equipment.
- External prosthetic devices that replace a limb or body part.

Benefits under this section do not include:

- Durable Medical Equipment provided to you by a Physician.
- Generally, any device, appliance, pump, machine stimulator, or monitor that is fully implanted into the body.

If you have any questions regarding whether a particular item is considered to be Durable Medical Equipment, please contact Care Coordination.

Care Coordination must be contacted for any purchase or rental of Durable Medical Equipment that exceeds [$1,000]. UnitedHealthcare will decide if the equipment should be purchased or rented.

Benefits that are available for repairs and replacement, except that:

- Benefits for repair and replacement do not apply to damage due to misuse, malicious breakage or gross neglect.
- Benefits are not available to replace lost or stolen items.
- Replacement of Durable Medical Equipment is limited to every three years, unless there are catastrophic circumstances, in which case you should notify UnitedHealthcare and an individual case evaluation will be performed.

If more than one piece of Durable Medical Equipment can meet your functional needs, benefits are available only for the equipment that meets the minimum specifications for your needs. If you rent or purchase a piece of Durable Medical Equipment that exceeds this guideline, you will be responsible for any cost difference between the piece you rent or purchase and the piece that UnitedHealthcare has determined is the most cost-effective.

Emergency Transportation Services

Transportation charges are covered for transportation to a Hospital in connection with an emergency.

The transportation services must be to a Hospital in your local area. If there are no local Hospitals that can provide the care needed, charges for transportation to the nearest Hospital outside your local area qualified to give the required treatment, will be covered.

Habilitative Services

Habilitative Services for children from birth to age 21 are covered, except for Habilitative Services provided in early intervention and school services.

Habilitative Services includes services, including occupational therapy, physical therapy, and speech therapy, for the treatment of a child with a congenital or genetic birth defect to enhance the child's ability to function. For purposes of Habilitaitive Services, a cogenital or genetic birth defect means a defect existing at or from birth, including a hereditary defect. A congential or genetic birth defect includes, but is not limited to (a) autism or autism spectrum disorder, and (b) cerebral palsy.

Home Health Care Agency Services

Charges for services of a Home Health Care Agency prescribed in writing by a Physician to be in lieu of Hospital confinement, up to a maximum of 30 visits during any one calendar year. Each visit by a member of a home health care team will be considered as one home health care visit. Four hours of home health care services will be considered as one home health care visit. If a visit exceeds four hours, each additional four hours, or part thereof, will count as one additional visit. Each visit by any other member of the home health care team will count as an additional visit.

The following services and supplies of a Home Health Care Agency are covered:

- Temporary or part-time nursing care by or supervised by a registered graduate nurse (R.N.).
- Temporary or part-time care by a home health aide.
- Physical therapy, occupational therapy or speech therapy.
- Medical supplies.
- Drugs and medications ordered by a Physician.
- X-ray and laboratory tests.

Hospice

Hospice care that is recommended by a Physician, for a period of up to six (6) months. Hospice care is an integrated program that provides comfort and support services for the terminally ill. Hospice care includes physical, psychological, social and spiritual care for the terminally ill person and short-term grief counseling for immediate family members while the patient is receiving hospice care.

You must notify and receive approval from Care Coordination prior to receiving any inpatient or outpatient hospice care in order to be eligible for this benefit.

Benefits are available when hospice care is received from a licensed hospice agency.

A Physician must certify that the patient is terminally ill and that the patient's life expectancy is six (6) months or less.

Hospital Services

Services and supplies provided by a Hospital on an inpatient basis, except that if charges are made for a private room, Covered Expenses will be limited to the hospital's average daily charge for a semi-private room.

Coverage is provided for up to 60 inpatient days per calendar year for alcoholism, chemical dependency and/or mental illness services. In addition, coverage is provided for up to 12 days per calendar year for inpatient detoxification services.

Coverage is also provided for newborn infant hearing screenings and all necessary audiological examinations provided as recommended by the national Joint Committee on Infant Hearing. For purposes of this coverage, "Hospital" shall include birthing centers or other centers having newborn nurseries.

Services and supplies provided by a Hospital on an outpatient basis including:

- Emergency care and treatment for a medical emergency, including the sudden onset or worsening of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent lay person, who possesses an average knowledge of health and medicine to result in:
  - Placing the patient's health in serious jeopardy;
  - Serious impairment to bodily functions; or
  - Serious dsyfunction of any bodily organ or part.
- Voluntary HIV screening test performed while receiving emergency care in a Hospital, once per calendar year, regardless of whether or not the HIV screening is necessary for the treatment of the condition for which the emergency care is sought..

Medical Supplies

- Medical and surgical supplies (such as bandages and dressings). Supplies given during surgery or a diagnostic procedure are included in the overall cost for that surgery or diagnostic procedure.
- Blood or blood derivatives only if not donated or replaced.

Multiple Surgical Procedures

When more than one surgical procedure is performed during the same operative session, Covered Expenses are limited as follows:

- Covered Expenses for the second procedure will be limited to 50% of the Reasonable Charge for that procedure had it been performed alone.
- Covered Expenses for any subsequent procedure are limited to 50% of the Reasonable Charge for the subsequent procedures.

Organ/Tissue Transplants

- Donor Charges

  In the case of an organ or tissue transplant, no services or supplies for the donor are considered Covered Health Services unless the recipient is the Employee or his/her Dependent. If the recipient is not the Employee or his/her Dependent, no benefits are payable for donor charges.

  The search for bone marrow/stem cell from a donor who is not biologically related to the patient is not considered a Covered Health Service UNLESS the search is made in connection with a transplant procedure arranged by a Transplant Facility.

- Qualified Procedures

  If a qualified procedure, listed below, is Medically Appropriate and performed at a Transplant Facility, the "Medical Care and Treatment" and "Transportation and Lodging" provisions set forth below apply:

    - Heart transplants
    - Heart/lung transplants
    - Liver transplants
    - Kidney transplants
    - Pancreas transplants
    - Kidney/pancreas transplants
    - Bone marrow/stem cell transplants
    - Other transplant procedures when UnitedHealthcare determines that it is necessary to perform the procedure at a Treatment Facility.

  If a transplant, even if determined to be Medically Appropriate, is not performed at a Transplant Facility, there will be no benefit payable for the "Medical Care and Treatment" or the "Transportation and Lodging" provisions set forth below.

- Medical Care and Treatment
  - The following services provided in connection with the transplant are Covered Health Services:
    - Pre-transplant evaluation for one of the procedures listed above
    - Organ acquisition and procurement
    - Hospital and Physician fees
    - Transplant procedures
    - Follow-up care for a period up to one year after the transplant
    - Search for bone marrow/stem cell from a donor who is not biologically related to the patient. If a separate charge is made for a bone marrow/stem cell search, a maximum benefit of $25,000 is payable for all charges made in connection with the search.

- Transportation and Lodging

  Care Coordination will assist the patient and family with travel and lodging arrangements. Expenses for travel, lodging and meals for the transplant recipient and a companion are available under this Plan as follows:

  - Reasonable and necessary expenses for transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of the transplant for the purposes of an evaluation, the transplant procedure or necessary post-discharge follow-up.
  - Reasonable and necessary expenses for lodging and meals for the patient (while not confined) and one companion. Benefits are paid at a per diem rate of up to $50 for one person or up to $100 for two people.

  Travel and lodging expenses are only available if the transplant recipient resides more than 50 miles from the Transplant Facility.

  If the Dependent who is the patient is a minor child, the transportation expenses of two companions will be covered and lodging and meal expenses will be reimbursed up to the $100 per diem rate.

  There is a combined overall lifetime maximum of $10,000 per Employee or Dependent for all transportation, lodging and meal expenses incurred by the transplant recipient and companion(s) and reimbursed under Plans A, B and C, combined, in connection with all transplant procedures.

Outpatient Alcoholism, Chemical Dependency and Mental Illness Services

Benefits for outpatient services to treat alcoholism, chemical dependency and/or mental illness. The Plan pays 75% of the Covered Expenses in a calendar year after the Deductible is satisfied for the first 40 outpatient visits for alcoholism, chemical dependency and/or mental illness, and then 60% of any additional visits.

Outpatient Rehabilitation

Short-term outpatient rehabilitation services, limited to:

- Physical therapy
- Occupational therapy
- Chiropractic treatment
- Speech therapy
- Pulmonary rehabilitation therapy
- Cardiac rehabilitation therapy

Rehabilitation services are limited to thirty (30) visits per calendar year for any combination of services.

Rehabilitation services must be performed by a Physician or by a licensed therapy provider. Benefits under this section include rehabilitation services provided in a Physician's office or on an outpatient basis at a Hospital.

We will pay benefits for speech therapy for the treatment of disorders of speech, language, voice, communication and auditory processing only when the disorder results from injury, stroke, cancer, congenital anomaly, or autism spectrum disorders.

Physician Services

Physician charges for professional services incurred:

- in a Physician's office;
- during a Hospital confinement;
- for the performance of a surgical operation; or
- in a Skilled Nursing Facility.

When determined to be a Covered Health Service, charges by an assistant surgeon are also covered under the plan.

Preventive Adult Health Services

- One routine physical examination per calendar year, subject to the calendar year Deductible.
- Necessary laboratory tests and/or immunizations, subject to the calendar year Deductible.
- Benefits are available for mammography testing that is consistent with the recommendations of governmental scientific agencies. Benefits for mammography testing are payable when mammography testing is performed as follows:
  - a baseline mammogram; and
  - follow-up mammograms on an annual basis.
- Pap smears are covered annually, or when it is determined by the attending physician that the test is necessary.

The preventive services listed above for mammograpy testing and pap smears are not subject to coinsurance or the calendar year Deductible.

- Colorectal cancer screenings are covered in compliance with the American Cancer Society colorectal cancer screenings guidelines.
- Prostate cancer screenings are covered in accordance with the latest screening guidelines used by the American Cancer Society.

Preventive Child Health Services

Benefits are available from birth to age 21 including:

- Coverage for injury or sickness, including the necessary care and treatment of medically diagnosed congenital defects, birth abnormalities, and prematurity; and

Coverage for preventive and primary care services, including physician examinations, measurements, sensory screening, neuropsychiatric evaluation, and development screening, which coverage shall include unlimited visits up to the age of 12 years, and 3 visits per year for minor children ages 12 years up to age 21 years of age. Preventive and primary care services shall also include, as recommended by the physician, hereditary and metabolic screening at birth, immunizations, urinalysis, tuberculin tests, and hematocrit, hemoglobin, and other appropriate blood tests, including tests to screen for sickle hemoglobinopathy.

Radiation Therapy

Skilled Nursing Facility

Services and supplies up to [20-60] days of confinement following each Hospital confinement per calendar year.

If charges are made for a private room, Covered Expenses will be limited to the facility's daily charge for a semi-private room.

Skilled nursing facility stays must be approved in advance by Care Coordination in order to be eligible for benefits.

Telehealth

Charges for services provided through telehealth rather than face-to-face consultation when the services can appropriately be provided through telehealth.

- "Telehealth" means the use of live, interactive audio and visual transmissions of a physician-patient encounter from one site to another using telecommunications technologies. They may include transmissions of real-time telecommunications or those transmitted by store-and-forward technology.

- Telemedicine services are medical services provided via ~~telephone, the Internet, or other communications networks or devices~~ interactive audio, video or other electronic media for the purpose of diagnosis, consultation, or treatment ~~that do not involve direct, in-person patient contact~~.

Treatment Center Services

Charges for services at a Treatment Center, when a Physician or Psychologist has certified an alcoholism or chemical dependency and has prescribed such services, up to a calendar year maximum of 60 days. In addition, detoxification services will be covered for up to 12 days annually.

Urgent Care Center Services

Charges for Covered Health Services received at an Urgent Care Center.

X-ray and Laboratory Tests

IMPORTANT: It should be noted that the Covered Expenses listed above do not include charges for drugs, private duty nursing, Physician's home visits, and some other services and supplies which are covered under the ~~Health & Welfare Plan~~Railroad Employees National Health and Welfare Plan, NRC/UTU Plan, GA-46000, the Amtrak Early Retirement Plan, the Keolis Commuter Services (formerly MBCR) Early Retirement Plan, the TransitAmerica Services, Inc. (TASI) Early Retirement Plan or GA-107300.

PREFERRED PROVIDERS

UnitedHealthcare has arranged with certain health care providers to become Preferred Providers. These Preferred Providers have agreed to discount their charges for Covered Expenses.

If Preferred Providers are used, the amount of Covered Expenses for which you are responsible will generally be less than the amount owed if other providers had been used. The percentage of Covered Expenses payable remains the same whether or not Preferred Providers are used. However, because the Covered Expenses may be less when Preferred Providers are used, the portion that you owe will be less.

You will receive an Identification Card showing that you and/or your Dependents Covered under Plans A, B or C, are entitled to these discounts. This Identification Card must be shown every time health care services are given. This is how the provider knows that you and/or your Dependent is covered under a Preferred Provider plan. Otherwise, you could be billed for the provider's normal charge.

Call UnitedHealthcare at 1-800-842-5252 to inquire about or locate Preferred Providers in your area. You may also access Preferred Provider information online at myuhc.com.

Preferred Providers are responsible for filing your claims directly to UnitedHealthcare. You do not need to submit claims for Preferred Providers services or supplies.

You must submit claims for services and supplies rendered by other providers as described in the section entitled Claim Information.

If a Preferred Provider bills you for any part of the discount amount, call UnitedHealthcare at 1-800-842-5252 for assistance.

CARE COORDINATION

Care Coordination is designed to encourage an efficient system of care for you and your Dependents by identifying possible unmet covered health needs. This may include admission counseling, inpatient care advocacy, and certain discharge planning and disease management activities. Care Coordination activities are not a substitute for the medical judgment of your Physician, however, and the ultimate decision as to what medical care you actually receive must be made by you and your Physician.

Care Coordination is triggered when UnitedHealthcare receives notification of an upcoming treatment or service. The notification process serves as a gateway to care coordination activities.

When to Notify Care Coordination

Care Coordination must be notified as soon as possible after you know that you require any of the services or supplies shown below:

- Inpatient admissions to a Hosptial or Skilled Nursing Facility
- Home health care
- Hospice care
- Durable medical equipment (over $1,000)
- Reconstructive procedures
- Dental services rendered as a result of an accident
- [Gender transformation surgery]

With regard to organ/tissue transplants, Care Coordination must be notified at least seven working days before the scheduled date of any of the following or as soon as reasonably possible:

- The evaluation of a transplant
- The donor search
- The organ procurement/tissue harvest
- The transplant procedure

For an in-patient confinement which is the result of an emergency, you (or your representative or Physician) must call Care Coordination within one day (excluding weekends and holidays) from the date the confinement begins.

You should notify Care Coordination promptly after you become aware that you are pregnant. You are required to give this notice, however, only if and when inpatient care for the mother or child is expected to continue beyond:

- 48 hours following a normal delivery; or
- 96 hours following a Caesarean section.

The notice you give must be given in sufficient time to allow UnitedHealthcare to complete a review of the matter before the services are rendered. In the absence of advance notice, UnitedHealthcare may not be able to complete its review and determine, before you incur expenses, if the service is a Covered Health Service, and if so, whether it is Medically Appropriate.

Remember: This notice obligation is your responsibility. It is not the responsibility of your Physician, your Hospital or any other provider.

~~The notification does not apply to injuries incurred by an Employee while on duty for an employing railroad, but UnitedHealthcare customer service representatives are available to answer questions about your proposed medical treatment.~~

How to Give the Required Notice

Notice should be given by telephone at 1-800-842-5252. You can call at any time, day or night. However, if you call outside of the normal hours of operation, you may leave a message with your telephone number on an answering machine, and your call will be returned within one working day.

What Happens After You Give the Required Notice?

UnitedHealthcare will review the services for which you have given notice and will determine whether they are Covered Health Services, and, if so, whether they are Medically Appropriate.

The ultimate decision on your medical care must be made by you and your Physician. Review by Care Coordination only determines whether the service or supply is a Covered Health Service, and if so, whether it is Medically Appropriate, solely for purposes of deciding what, if any, amounts are payable with respect to the service or supply under the Plan.

Effects on Benefits

- Benefits are reduced if you do not give the required notice or if UnitedHealthcare determines that the service or supply, although a Covered Health Services, is not Medically Appropriate. In either case, the benefit will be reduced from [60-80]% to [50-70]% of the benefits payable under the Plan. If you have satisfied your Out-of-Pocket Maximum, benefits will be reduced from 100% to [70-90]%.

- No benefits are payable if UnitedHealthcare determines that the service or supply is not a Covered Health Service.

If UnitedHealthcare determines that a service is not a Covered Health Service or is not Medically Appropriate, you or your Physician can appeal that determination. Please see the Claim Information section for a description of the appeal process.

Case Management Services

UnitedHealthcare also provides case management services. These services focus on severe illnesses and injuries which could result in long-term hospital confinements. UnitedHealthcare will determine whether case management services are appropriate in your case.

Through case management services, benefits for alternative treatment, which are otherwise not Covered Health Services, may be offered to you or your Dependent when it is appropriate and cost effective. The decision to accept alternative treatment rests with the patient and Physician.

Disease Management Services

UnitedHealthcare also provides disease management services. These programs focus on providing information about certain chronic medical conditions, such as heart failure, coronary artery disease, diabetes, or asthma, and the ways these conditions can be treated or managed. If you have been diagnosed with a chronic medical condition, UnitedHealthcare may contact you to discuss this program. Or you may call UnitedHealthcare at 1-800-842-5252 to learn whether you are eligible to participate in a program. Participation is voluntary, and there is no charge for these services.

Through disease management services, benefits for alternative treatment, which are otherwise not Covered Health Services, may be offered to you or your Dependent when it is appropriate and cost effective. The decision to accept alternative treatment rests with the patient and Physician.

Telephonic Access to Nurses and Counselors

UnitedHealthcare provides a toll-free telephone number that puts you in immedicate contact with a registered nurse any time, 24 hours a day, seven days a week. These nurses can provide health information for routine or urgent health concerns, such as a recent diagnosis, a minor sickness or injury, or other health-related topics. You can also listen to pre-recorded messages on a variety of medical topics.

This service is available to you and your Dependents at no charge. To use it, you can call UnitedHealthcare at 1-866-735-5685.

WELLNESS PROGRAMS

Healthy Weight Program

UnitedHealthcare provides a non-surgical approach to addressing weight and obesity through nutritional and activity guidance. You may receive free educational information on the web or through the mail and may even be called by a health coach who is a specialist in weight management. This health coach will be a resource to advise and help you manage your weight.

This program offers:

- on-line self-help tools: health assessment, exercise tracker, meal planner, calorie counter and educational content;
- education on weight management and self-care strategies;
- nutritional guidance and counseling by a health coach and registered dietician (if needed); and
- activity recommendations and encouragement by a health coach and exercise physiologist (if needed).

Participation is completely voluntary and without extra charge. If you think you would like to participate or would like additional information regarding the program, please call the number on the back of your ID card.

Tobacco Cessation Program

UnitedHealthcare provides a tobacco cessation program to help smokers withdraw from nicotine dependence. By participating in this program, you will receive educational material through the mail and one on one telephone sessions with trained cessation specialists.

This program offers:

- a quit smoking kit that includes a cessation manual and quit aids designed to provide support through this program;
- toll-free telephone access to cessation specialists (you will receive five (5) coaching sessions and may place unlimited calls to the cessation specialists when you have a question); and
- medication recommendations, and/or free over-the-counter nicotine replacement therapies if you or your Dependent are over the age of 18.

Participation is completely voluntary and without extra charge. If you think you would like to participate or would like additional information regarding the program, please call the number on the back of your ID Card.

Health Assessment

You and your spouse are invited to learn more about your health and wellness at **myuhc.com** and are encouraged to participate in the online health assessment. The health assessment is an interactive questionnaire designed to help you identify your healthy habits as well as potential health risks.

Your health assessment is kept confidential. Completing the assessment will not impact your benefits or eligibility for benefits in any way.

To find the health assessment, log in to **myuhc.com**. After logging in, access your personalized *Health & Wellness* page and click the *Health Assessment* link. If you need any assistance with the online assessment, please call the number on the back of your ID card.

[Next Steps

Individuals that complete a health assessment and are identified with three or more high risk factors, will be provided with telephonic outbound coaching. Coaching will be provided for any/all of the following topics, as appropriate; participation is completely voluntary and without extra charge:

- exercise,
- blood pressure management;
- smoking cessation;
- nutrition;
- stress management;
- cholesterol management; and
- back care/ergonomics.]

VI

PLAN E

APPLICABLE TO PERSONS ELIGIBLE UNDER THE RAILROAD EMPLOYEES NATIONAL EARLY RETIREMENT MAJOR MEDICAL BENEFIT PLAN (GA-46000)

This Plan has been developed to supplement the benefits for retired and disabled railroad Employees and their Dependents who qualify for coverage under GA-46000. Coverage under GA-46000 is provided by the participating railroads at no cost to eligible Employees.

In general, eligibility for coverage on the basis of age under GA-46000 is limited to Employees who apply to a "60/30" annuity under the Railroad Retirement Act of 1974 subject to the following requirements:

- Application for the "60/30" annuity is made on or after the date the Employee attains age 60.
- The Employee was covered under the ~~Health & Welfare Plan~~Railroad Employees National Health and Welfare Plan ~~and~~ or the NRC/UTU Plan on the day before the application for the "60/30" annuity is made.

However, Employees may apply for an annuity during the three months before their 60th birthday if they continue working or receive vacation pay into the month prior to the month in which their 60th birthday occurs. Employees will not be disqualified from participation in this Plan, provided they satisfy the other eligibility requirements.

In addition, GA-46000 covers certain disabled Employees who were still covered under the ~~Health & Welfare Plan~~Railroad Employees National Health and Welfare Plan ~~and~~ or the NRC/UTU Plan when they reached age 60. The disability qualification requirements are quite specific and any questions in this regard should be directed to your Employer, your Labor Organization or UnitedHealthcare, Railroad Administration, 450 Columbus Boulevard, P.O. Box 150476, Hartford, CT 06115-0476. A booklet containing a complete description of the rules governing eligibility for GA-46000 benefits is available through employing railroads.

If you qualify for coverage under GA-46000 you may enroll for Employee and/or Dependent benefits under Plan E provided your enrollment and payment are mailed (postmarked) to UnitedHealthcare on or before the last day of the month in which coverage under the ~~Health & Welfare plan~~Railroad Employees National Health and Welfare Plan or NRC/UTU Plan terminates or in the next three calendar months. If your benefits under ~~the Railroad Employees National Early Retirement Major Medical Benefit Plan~~an early retirement medical plan are paid by a hospital association, you may enroll for Dependent benefits only.

Your Employee coverage under GA-46000 ceases when you become eligible for Medicare due to age or disability. If you become eligible for Medicare due to end stage renal disease, your coverage under GA-46000 ends, after you have been eligible for Medicare for 30 months. If you qualify for Medicare due to age (65), your coverage under Plan E will be automatically transferred to Plan F. If you qualify for Medicare for reasons other than age, you must notify UnitedHealthcare so that coverage can be transferred from Plan E to Plan F.

Keep in mind that your Dependent coverage under GA-46000 terminates when you qualify for Medicare due to age (65). In the event of your death, your Dependent(s) will be covered until you would have qualified for Medicare due to age (65). When your Dependent(s) are no longer covered under GA-46000, coverage for Dependent(s) will automatically be transferred from Plan E to Plan C. If you would prefer to enroll your Dependent(s) in either Plan A or Plan B, of if you want to decline coverage for your Dependent(s), you will have to call UnitedHealthcare at 1-800-842-5252.

Your Dependents may be entitled to continue coverage under GA-46000 after it would otherwise terminate as a result of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Full information concerning COBRA has been made available to persons covered under GA-46000. If your Dependents are continuing GA-46000 coverage under COBRA, your Dependents benefits will remain under Plan E. When their COBRA continuation coverage terminates, their GA-23111 coverage will automatically be transferred to Plan F if they are entitled to Medicare, or Plan C if they are not entitled to Medicare. If your Dependents are not entitled to Medicare, and you would prefer them to be enrolled in either Plan A or Plan B, or if you want to decline coverage for your Dependents, you will have to call UnitedHealthcare at 1-800-842-5252.

Coverage under GA-46000 for an individual Dependent will cease when that Dependent becomes eligible for Medicare. When this occurs, you must notify UnitedHealthcare so that coverage can be transferred from Plan E to Plan F.

MAJOR MEDICAL EXPENSE BENEFITS

The Plan pays [60% - 80%] (75% for the first 40 outpatient visits for alcoholism, chemical dependency and/or mental illness and 60% for any visits thereafter) of the Covered Expenses incurred in a calendar year which exceed the Deductible.

DEDUCTIBLE

The Deductible is separate for you and each of your Dependents each calendar year. It has two parts - a Basic Benefits Deductible and a Cash Deductible.

Basic Benefits Deductible

The Basic Benefits Deductible is the total payments made during the calendar year under GA-46000 or, if the benefits under GA-46000 are reduced in accordance with its Coordination of Benefits provisions, the payments which would have been made had such reduction not occurred.

Cash Deductible

The Cash Deductible is $[100 – 500].

PERCENTAGE OF COVERED EXPENSES PAYABLE

The Plan pays [60–80]% (75% for the first 40 outpatient visits for alcoholism, chemical dependency and/or mental illness and 60% for any visits thereafter) of Covered Expenses in a calendar year after the Deductible is satisfied.

The Plan pays 100% of the Covered Expenses in a calendar year after the Out-of-Pocket Maximum is met.

OUT-OF-POCKET MAXIMUM

The Out-of-Pocket Maximum limits the amount of Covered Expenses you will have to pay for any one covered individual in a calendar year. The Out-of-Pocket Maximum each calendar year is $[5,000 – 15,000]. Covered Expenses used to satisfy your Deductible are also used to help satisfy your Out-of-Pocket Maximum.

The following expenses do not count in determining if any Out-of-Pocket Maximum has been met:

- Charges you pay that are in excess of the Reasonable Charge.
- Charges you pay that are in excess of specific Plan limitations or exclusions.
- Charges you pay for expenses not covered by the Plan.
- Charges you pay as a result of a reduction in benefits under GA-46000 if the required Care Coordination notification is not made, or if Care Coordination determines that the service or supply is not a Covered Health Service as that term is defined under GA-46000.
- Co-payments you make and any other charges you pay under the GA-46000 Managed Pharmacy Services Benefit.

MAXIMUM AMOUNT

The Maximum Amount payable with respect to you or any one of your Dependents is $[300,000 – 1,000,000]. This Maximum Amount applies to a person's entire lifetime.

COVERED EXPENSES

Covered Expenses are the actual cost to you of the Reasonable Charges (see Definitions) for the Covered Health Services (see Definitions) listed below. The service or supply must be needed because of injury, sickness or pregnancy.

A service or supply is not a Covered Health Service just because it is furnished by, or ordered by, your provider. The services and supplies will be reviewed by UnitedHealthcare to determine if they are covered under the Plan.

The services and supplies for which Covered Expenses may be incurred are as follows:

Ambulatory Surgical Center Services

Services given within 72 hours before or after a surgical procedure. The services have to be given in connection with the procedure.

Anesthetics

Applied Behavioral Analysis Services

Applied Behavioral Analysis (ABA) services for Autism Spectrum Disorders that are:

- Focused on the treatment of core deficits of Autism Spectrum Disorder;
- Provided by a *Board Certified Applied Behavioral Analyst (BCBA)* or other qualified provider under the appropriate supervision; and
- Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property, and impairment in daily functioning.
- Services include the following:
- Diagnostic evaluations, assessment and treatment planning.
- Treatment and/or procedures.
- Medication management and other associated treatments.
- Individual, family, and group therapy.
- Provider-based case management services.
- Crisis intervention.

Birth Center Services

Chemotherapy

Clinical Trials

Routine patient care costs incurred during participation in an approved clinical trial meeting the approved clinical trial criteria stated below.

Benefits include the reasonable and necessary items and services used to diagnose and treat complications arising from participation in an approved clinical trial.

Benefits are available only when the Covered Family Member is clinically eligible for participation in the clinical trial as defined by the researcher. Benefits are not available for preventive clinical trials.

Routine patient care costs for clinical trials include:

- Covered Health Services for which benefits are typically provided absent a clinical trial.
- Covered Health Services required solely for the provision of the investigational item or service, the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications.
- Covered Health Services needed for reasonable and necessary care arising from the provision of an investigational item or service.

Routine costs for clinical trials do not include:

- The Experimental or Investigational Service or item. The only exceptions to this are:
  - Certain Category B devices.
  - Certain promising interventions for patients with terminal illnesses.
  - Other items and services that meet specified criteria in accordance with our medical policy guidelines.
- Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.
- Items and services provided by the research sponsors free of charge for any person enrolled in the trial.

To be an approved clinical trial, a clinical trial must meet all of the following criteria:

- Be approved and funded in full or in part by one or more of the following:
  - National Institutes of Health (NIH). (Includes National Cancer Institute (NCI).)
  - Centers for Disease Control and Prevention (CDC).
  - Agency for Healthcare Research and Quality (AHRQ).
  - Centers for Medicare and Medicaid Services (CMS).
  - A bona fide clinical trial cooperative group, including the National Cancer Institute Clinical Trials Cooperative Group, the National Cancer Institute Community Clinical Oncology Program, the AIDS Clinical Trials Group, and the Community Programs for Clinical Research in AIDS.
  - The Department of Defense (DOD), the Department of Veterans Affairs, or the Department of Energy, or a qualified nongovernmental research entity to which the National Cancer Institute has awarded a support grant.
  - A study or investigation approved by the Food and Drug Administration (FDA), including those conducted under an investigational new drug or device application reviewed by the FDA.
  - An investigation or study approved by an Institutional Review Board registered with the Department of Health and Human Services that is associated with an institution that has a federal-wide assurance approved by the Department of Health and Human Services specifying compliance with federal regulations.
- The clinical trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (IRBs) before participants are enrolled in the trial. We may, at any time, request documentation about the trial to confirm that the clinical trial meets current standards for scientific merit and has the relevant IRB approvals.

The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Service and is not otherwise excluded under the Policy.

Diabetes Treatment

Coverage for diabetic equipment, diabetes supplies and in-person outpatient diabetic self-management training and education programs (including medical nutrition therapy) when provided under the direction of a Physician by a certified, registered or licensed health care professional.

Diabetes self-management training includes training provided to a Covered Person after the initial diagnosis in the care and management of that condition, including nutritional counseling and proper use of diabetes equipment and supplies. Coverage is also provided for additional training upon diagnosis of a significant change in medical condition that requires a change in the self-management regime, and a periodic continuing education training as warranted by the development of new techniques and treatment for diabetes.

Durable Medical Equipment

Durable Medical Equipment means equipment that meets all of the following criteria:

- It is for repeated use and is not consumable or disposable
- It is used primarily for a medical purpose
- It is appropriate for use in the home

Some examples of durable medical equipment are:

- Appliances that replace a lost body organ or part or help an impaired one to work
- Orthotic devices such as arm, leg, neck and back braces
- Hospital-type beds
- Equipment needed to increase mobility, such as a wheelchair
- Respirators or other equipment for the use of oxygen
- Monitoring devies

Care Coordination must be contacted for any purchase or rental costs which exceed [$1,000]. Care Coordination will determine whether the purchase or rental of the equipment is Medically Appropriate.

Habilitative Services

Habilitative Services for children from birth to age 21 are covered, except for Habilitative Services provided in early intervention and school services.

Habilitative Services includes services, including occupational therapy, physical therapy, and speech therapy, for the treatment of a child with a congenital or genetic birth defect to enhance the child's ability to function. For purposes of Habilitaitive Services, a cogenital or genetic birth defect means a defect existing at or from birth, including a hereditary defect. A congential or genetic birth defect includes, but is not limited to (a) autism or autism spectrum disorder, and (b) cerebral palsy.

Home Health Care Agency Services

- Part-time or intermittent nursing care rendered by or supervised by a registered nurse.
- Part-time or intermittent care by a home health aide.
- Physical therapy or occupational therapy.
- Speech therapy to restore speech lost or impaired due to removal of vocal cords, cerebral thrombosis, or brain damage due to injury or organic brain lesion.
- Prescription Drugs.
- Medical Supplies.
- X-rays and laboratory tests.

Hospice Care Services

Up to a maximum payment of [$3,000] for each Course of Care for room, board, care and treatment charged by a Hospice.

Up to a maximum payment of [$1,000] for each Course of Care for:

- Counseling for the patient's Immediate Family. Services must be given by a licensed social worker or a licensed pastoral counselor.
- Bereavement counseling up to [15] visits for the patient's Immediate Family. Services must be given by a licensed social worker or a licensed pastoral counselor and given within six months after the patient's death.

The Physician must certify that the patient is terminally ill with 6 months or less to live.

"Immediate Family" means you or any member of your family who is covered under this Plan.

"Course of Care" means all services given to the patient and the patient's Immediate Family in connection with the terminal illness of the patient.

Services provided by a licensed pastoral counselor to a member of his/her congregation in the course of his/her normal duties as a pastor or minister will not be considered a Covered Expense.

Hospital Services

Services and supplies provided by a Hospital on an inpatient or outpatient basis.

If charges are made for a private room, Covered Expenses will be limited to the hospital's average daily charge for a semi-private room.

Coverage is also provided for up to 60 inpatient days per calendar year for alcoholism, chemical dependency and/or mental illness services. In addition, coverage is provided for up to 12 days per calendar year for inpatient detoxification services.

Coverage is also provided for newborn infant hearing screenings and all necessary audiological examinations provided as recommended by the National Joint Committee on Infant Hearing. For purposes of this coverage, "Hospital" shall include birthing centers or other centers having newborn nurseries.

Services and supplies provided by a Hospital for emergency care and treatment for a medical emergency, including the sudden onset or worsening of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent lay person, who possesses an average knowledge of health and medicine to result in:

- Placing the patient's health in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dsyfunction of any bodily organ or part.

Coverage is also provided for the cost of a voluntary HIV screening test performed while receiving emergency care in a Hospital, once per calendar year, regardless of whether or not the HIV screening is necessary for the treatment of the condition for which the emergency care is sought.

Infertility Treatment

Diagnosis and treatment of infertility, including surgery and drug therapy. This does not include procedures or services to facilitate a pregnancy, such as, but not limited to, in vitro fertilization, embryo transfer, artificial insemination and immunotherapy for infertility.

Medical Supplies

- Surgical supplies (such as bandages and dressings). Supplies given during surgery or a diagnostic procedure are included in the overall cost for that surgery or diagnostic procedure.
- Blood or blood plasma only if not donated or replaced.

Nursing Services

Services of a trained nurse or a Nurse-Midwife.

Occupational Therapy

Servies of a licensed occupational therapist provivded the following conditions are met:

- The therapy must be ordered and monitored by a Physician.
- The therapy must be given in accordance with a written treatment plan approved by a Physician. The therapist must submit progress reports to the Physician at the intervals stated in the treatment plan.
- The therapy must be expected to result in significant, objective, measurable physical improvement within 2 months of the start of treatment.

Organ/Tissue Transplants

- Donor Charges

  In the case of an organ or tissue transplant, no services or supplies for the donor are considered Covered Health Services unless the recipient is the Employee or his/her Dependent. If the recipient is not the Employee or his/her Dependent, no benefits are payable for donor charges.

  The search for bone marrow/stem cell from a donor who is not biologically related to the patient is not considered a Covered Health Service UNLESS the search is made in connection with a transplant procedure arranged by a Transplant Facility.

- Qualified Procedures

  If a qualified procedure, listed below, is Medically Appropriate, the "Medical Care and Treatment" provisions set forth below apply:

  - Heart transplants
  - Heart/lung transplants
  - Liver transplants
  - Kidney transplants
  - Pancreas transplants
  - Kidney/pancreas transplants
  - Bone marrow/stem cell transplants
  - Other transplant procedures when UnitedHealthcare determines that it is necessary to perform the procedure at a Treatment Facility.

- Medical Care and Treatment
  - The following services provided in connection with the transplant are Covered Health Services:
    - Pre-transplant evaluation for one of the procedures listed above
    - Organ acquisition and procurement
    - Hospital and Physician fees
    - Transplant procedures
    - Follow-up care for a period up to one year after the transplant
    - Search for bone marrow/stem cell from a donor who is not biologically related to the patient. If a separate charge is made for a bone marrow/stem cell search, a maximum benefit of $25,000 is payable for all charges made in connection with the search.

- Transportation and Lodging

  The following benefits for transportation and lodging expenses are available for those Medically Appropriate Qualified Procedures, as listed above, that are performed at a Transplant Facility. If a Transplant Facility is not used, then these transportation and lodging benefits will not be covered.

  Care Coordination will assist the patient and family with travel and lodging arrangements. Expenses for travel, lodging and meals for the transplant recipient and a companion are available under this Plan as follows:

  - Reasonable and necessary expenses for transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of the transplant for the purposes of an evaluation, the transplant procedure or necessary post-discharge follow-up.
  - Reasonable and necessary expenses for lodging and meals for the patient (while not confined) and one companion. Benefits are paid at a per diem rate of up to $50 for one person or up to $100 for two people.

  Travel and lodging expenses are only available if the transplant recipient resides more than 50 miles from the Transplant Facility.

  If the Dependent who is the patient is a minor child, the transportation expenses of two companions will be covered and lodging and meal expenses will be reimbursed up to the $100 per diem rate.

There is a combined overall lifetime maximum of $10,000 per Employee or Dependent for all transportation, lodging and meal expenses incurred by the transplant recipient and companion(s) and reimbursed under this Plan E [and Plans A, B and/or C, combined], in connection with all transplant procedures.

Outpatient Alcoholism, Chemical Dependency and Mental Illness Services

Benefits for outpatient services to treat alcoholism, chemical dependency and/or mental illness. The Plan pays 75% of the Covered Expenses in a calendar year after the Deductible is satisfied for the first 40 outpatient visits for alcoholism, chemical dependency and/or mental illness, and then 60% of any additional visits.

Physical Therapy

Services of a licensed physical therapist, provided the following conditions are met:

- The therapy must be ordered and monitored by a Physician.
- The therapy must be given in accordance with a written treatment plan approved by a Physician.
- The therapist must submit progress reports to the Physician at the intervals stated in the treatment plan.

The therapy must be expected to result in significant, objective, measurable physical improvement within two months of the start of the treatment.

Physicians Services

Prescription Drugs

Prescription drugs other than those obtained from a retail pharmacy or by mail order.

Prescription Contraceptive Devices

Devices approved by the U.S. Food and Drug Administration for the prevention of a pregnancy are covered for female employees and the wives of male employees.

Preventive Adult Health Services

- Benefits are available for mammography testing that is consistent with the recommendations of governmental scientific agencies. Benefits for mammography testing are payable when mammography testing is performed as follows:
  - a baseline mammogram; and
  - follow-up mammograms on an annual basis.
- Pap smears are covered annually, or when it is determined by the attending physician that the test is necessary.

The preventive services listed above are not subject to coinsurance or the calendar year Deductible.

- Colorectal cancer screenings are covered in compliance with the American Cancer Society colorectal cancer screenings guidelines.
- Screenings in accordance with the latest screening guidelines issued by the American Cancer Society.

Preventive Child Health Services

Benefits are available from birth to age 21 including:

- Coverage for injury or sickness, including the necessary care and treatment of medically diagnosed congenital defects, birth abnormalities, and prematurity; and
- Coverage for preventive and primary care services, including physician examinations, measurements, sensory screening, neuropsychiatric evaluation, and development screening, which coverage shall include unlimited visits up to the age of 12 years, and 3 visits per year for minor children ages 12 years up to age 21 years of age. Preventive and primary care services shall also include, as recommended by the physician, hereditary and metabolic screening at birth, immunizations, urinalysis, tuberculin tests, and hematocrit, hemoglobin, and other appropriate blood tests, including tests to screen for sickle hemoglobinopathy.

Psychologist Services

Radiation Therapy

Rehabilitative Services

Benefits for occupational therapy, speech therapy and physical therapy for Dependent children, under the age of 21, with congenital or birth defects (including autism and cerebral palsy).

Skilled Nursing Facility Care After Hospital Confinement

Services and supplies up to 31 days of confinement following each Hospital confinement.

Separate confinements for the same cause are considered to be one confinement, unless separated by 14 or more days.

If charges are made for a private room, Covered Expenses will be limited to the facility's daily charge for a semi-private room.

Speech Therapy

These services must be given to restore speech. The speech must have been lost or impaired due to one of the following:

- Removal of vocal cords.
- Cerebral thrombosis (cerebral vascular accident).
- Brain damage due to injury or organic brain lesion (aphasia).

The therapy must be expected to result in significant, objective, measurable physical improvement within two months of the start of the treatment.

Spinal Manipulations

Services of a physician given for the detection or correction (manipulation) by manual or mechanical means of structural imbalance or distortion in the spine.

No benefits are available for any type of therapy, service or supply, including, but not limited to, spinal manipulation by a chiropractor or other phsycian once the therapy, service or supply ceases to be therapeutic and is instead administered to maintain a level of functioning or to prevent a medical problem from occuring or reoccurring.

Telehealth

Charges for services provided through telehealth rather than face-to-face consultation when the services can appropriately be provided through telehealth.

- "Telehealth" means the use of live, interactive audio and visual transmissions of a physician-patient encounter from one site to another using telecommunications technologies. They may include transmissions of real-time telecommunications or those transmitted by store-and-forward technology.

- Telemedicine services are medical services provided via ~~telephone, the Internet, or other communications networks or devices~~ interactive audio, video or other electronic media for the purpose of diagnosis, consultation, or treatment that do not involve direct, in-person patient contact.

Transportation Services

Transportation charges are covered for transportation to a Hospital in an emergency.

The transportation services must be to a Hospital in your local area. If there are no local Hospitals that can provide the care needed, charges for transportation to the nearest Hospital outside your local area qualified to give the required treatment, will be covered.

Treatment Center Services

Charges for services at a Treatment Center when a Physician or Psychologist has certified an alcoholism or chemical dependency and has prescribed such services, up to a calendar year maximum of 60 days. In addition, detoxification services will be covered for up to 12 days annually.

X-ray and Laboratory Tests

EXCLUSIONS

Major Medical Expenses Benefits are not payable for expenses for:

- Expenses for any confinement, treatment, services or supplies which would have been payable under GA-46000, but which were not payable due to you or your Dependent's non-compliance with Care Coordination described under GA-46000.
- Prescription Drugs purchased from a pharmacy or by mail order.
- Expenses for treatment of on-duty injuries if the railroad has paid those expenses.

Other exclusions that apply to this Benefit are in the General Exclusions section.

VII
PLAN F

APPLICABLE TO PERSONS ELIGIBLE FOR FULL MEDICARE COVERAGE

This plan is available to Persons Eligible Under Medicare who are not eligible under the ~~Health & Welfare Plan~~Railroad Employees National Health and Welfare Plan, the [NRC/UTU Plan], GA-46000, GA-107300, the Amtrak Early Retirement Plan, the Keolis Commuter Services (formerly MBCR) Early Retirement Plan, or the TransitAmerica Services, Inc. (TASI) Early Retirement Plan.

INFORMATION ABOUT MEDICARE

An individual becomes eligible under Medicare:

- On the basis of **age,** on the first day of the month in which he or she attains age 65 (if an individual's birthday is on the first day of the month, he is considered to reach 65 in the previous month).
- On the basis of **disability,** on the first day of the month following receipt of disability benefits for 24 consecutive months under Railroad Retirement or Social Security. There is a waiting period of 5 full calendar months of disability before disability benefits begin. To be eligible for Medicare, a Railroad Retirement beneficiary must meet the disability qualifications of the Social Security Act which require that an individual be totally disabled (unable to perform the duties of any occupation).
- On the basis of **end stage renal disease,** on the first day of the third month after the month in which a course of renal dialysis is initiated, or when a kidney transplant is received.

Individuals who are receiving age or disability benefits under Social Security or Railroad Retirement will be automatically enrolled under Medicare. No payment is required under Part A of Medicare. The required payment under Part B of Medicare will be deducted automatically from the individual's monthly benefit. An individual may file a waiver form with Social Security or Railroad Retirement declining Part B coverage. If the individual does so, no deduction will be made from the monthly benefit but the individual will not have the maximum available coverage.

Individuals age 65 or over who are not otherwise eligible for coverage under Part A of Medicare may voluntarily enroll for such coverage. These individuals must pay the full cost of such coverage and must also enroll for coverage under Part B of Medicare.

An individual with end stage renal disease will have to enroll under Medicare in order to have coverage for Medicare benefits. Information about such enrollment should be obtained from a Railroad Retirement Board or Social Security Administration office.

INFORMATION ABOUT PLAN F

Plan F is not a replacement for Medicare. Any individual eligible for Medicare who declines Medicare benefits, or who fails to enroll, will lose whatever benefits Medicare could have paid. Plan F benefits will be paid as if the individual had enrolled in Medicare.

When you or your spouse attain age 65 while covered under Plan A, B, C, E, M or P, the coverage will automatically be changed to Plan F as of the first day of the month in which you or your spouse attain age 65. You will then be billed and should make payment in the amount applicable to Plan F.

When UnitedHealthcare is notified that a disabled individual or an individual with end stage renal disease becomes eligible under Medicare while covered under Plan A, B, C, E, M or P, that individual will be moved to Plan F. The required payment rate will be adjusted accordingly. For individuals covered under Plan E, M or P, coverage will not be changed until the individual's coverage under GA-46000, the Amtrak

Early Retirement Plan, the Keolis Commuter Services (formerly MBCR) Early Retirement Plan or the TransitAmerica Services, Inc. (TASI) Early Retirement Plan ends.

To avoid undue delay in making the necessary change, immediately notify UnitedHealthcare's Railroad Administration when the individual first becomes eligible under Medicare.

If coverage for one of your Dependents is changed to Plan F because that Dependent is eligible under Medicare, and you have additional Dependents who are not eligible under Medicare, you may be able to continue coverage for those additional Dependents under Plans A, B, C, E, M or P.

Benefits under Plan A, B, C, E, M or P will cease on the date an individual is eligible to be covered under Medicare. However, such individual can become covered under Plan F.

It is important that you notify UnitedHealthcare when you or one of your Dependents becomes eligible under Medicare.

See the section entitled **When To Enroll** for important information about Medicare Advantage.

Medicare benefits are sometimes awarded on a retroactive basis. When a retroactive award is made, Medicare usually offers the individual a choice to have Medicare Part B effective currently, or retroactive to the original effective date. Part A is always made effective as of the original effective date. If a retroactive effective date for Medicare Part B is selected, the individual must pay the Medicare Part B premium for each month of retroactive coverage.

An individual who receives a retroactive award may have paid for coverage under Plans A, B, C, E, M or P between the original Medicare effective date and the date of the award. Benefits under one of those plans may have been paid. In all such cases, the individual must reimburse UnitedHealthcare for all benefits paid under Plans A, B, C, E, M or P for services rendered on or after the original Medicare effective date. The individual may choose between the following options:

1. **Elect coverage under Plan F retroactive to the original Medicare effective date. Premiums paid under any other GA- 23111 plan will be applied for Plan F coverage, and all expenses incurred will be reconsidered under Plan F.**
2. **Cancel GA-23111 coverage retroactive to the original Medicare effective date. Premiums paid under any other GA-23111 plan will be used to offset any benefits paid under the other plan. Premiums paid in excess of benefits paid will be reimbursed.**

An individual electing the second option may enroll under Plan F effective the first of the month following the month the individual notifies UnitedHealthcare of the retroactive Medicare award.

HOSPITAL EXPENSE BENEFITS

Plan F covers confinement in a Hospital provided that benefits are also payable by Part A Medicare for the confinement.

The following benefits will be paid in full during each benefit period:

- The amount of the Medicare Part A deductible for the first 60 days.
- The amount of the Medicare Part A coinsurance for each day from the 61st through the 90th day.
- The amount of the Medicare Part A coinsurance for each day that Medicare lifetime reserve days are used.

If you exhaust all Medicare Part A benefits in a benefit period, Plan F will pay 100% of the Reasonable Charge (see Definitions) for the Covered Health Services (see Definitions) provided by the Hospital for up to 365 days of Hospital confinement during your lifetime.

A benefit period is defined by Medicare. It begins on the day you are admitted to a Hospital. It ends when you have been out of a Hospital or Skilled Nursing Facility for 60 straight days. It also ends if you are in a Skilled Nursing Facility but have not received skilled care there for 60 straight days.

EXCLUSIONS

Hospital Expense Benefits are not payable for any day of confinement during which lifetime reserve days are available, but you do not use them.

Hospital Expense Benefits are not payable for any day of confinement in a Hospital which does not participate in Medicare, except when required by applicable federal or state law. In such cases, Hospital Expense Benefits will be paid as if the Hospital did participate in Medicare. For the first 90 days of the confinement, and for any days during which Medicare lifetime reserve days would otherwise be payable. Hospital Expense Benefits will be limited to the Medicare Part A deductible and coinsurance amounts described above.

Hospital Expense Benefits are not payable for any day of confinement in a psychiatric Hospital which participates in Medicare after the maximum Medicare lifetime benefit has been reached.

If charges are made for a private room, payment will be limited to the Hospital’s average charge for a semi-private room.

Other exclusions that apply to this Benefit are in the General Exclusions section.

SKILLED NURSING FACILITY EXPENSE BENEFITS

Plan F covers confinement in a Skilled Nursing Facility provided that benefits are also payable by Medicare Part A for the confinement.

Payment will be made for Skilled Nursing Facility charges during a benefit period for an amount up to the Medicare Part A coinsurance for the 21st to the 100th day of confinement.

A benefit period is defined by Medicare. It begins on the day you are admitted to a Hospital. It ends when you have been out of a Hospital or Skilled Nursing Facility for 60 straight days. It also ends if you are in a Skilled Nursing Facility but have not received skilled care there for 60 straight days.

EXCLUSIONS

Skilled Nursing Facility Expenses Benefits are not payable for any day of confinement unless Medicare Part A benefits are also payable for that day, except when required by applicable federal or state law. In such cases, Skilled Nursing Facility Expense Benefits will be paid as if the Skilled Nursing Facility did participate in Medicare. For the first 20 days of the confinement, no benefits will be payable. For the next 80 days of the confinement, Skilled Nursing Facility Expense Benefits will be limited to the Medicare Part A coinsurance amounts described above.

Other exclusions that apply to this Benefit are in the General Exclusions section.

MEDICAL EXPENSE BENEFITS

Plan F covers medical care treatment which is eligible for payment under Medicare Part B.

The following amounts **will be paid in full**:

- The amount of the Medicare Part B deductible.
- The amount of the Medicare Part B coinsurance (generally 20% of the Medicare approved charges for most Medicare Part B services).
- In the event a provider does not accept a Medicare assignment, the amount over and above the amount of the Medicare approved charge, up to the amount of charge limitations set by either Medicare or state law. This amount is often referred to as "Medicare Part B excess charges".
- The amount you pay for up to three pints of blood per calendar year. This includes blood provided on an inpatient basis (covered under Medicare Part A) or an outpatient basis (covered under Medicare Part B). Charges for blood you have replaced yourself, or which was replaced by another person donating on your behalf, are not covered under this provision.

Plan F also covers medical care and treatment for certain expenses that are not eligible for payment under Medicare Part B. These Covered Expenses are listed below. They are the actual cost to you of the Reasonable Charge (see Definitions) for Covered Health Services (see Definitions) and supplies not payable by Medicare Part B listed below. The service or supply must be needed because of injury, sickness or pregnancy. Plan benefits are paid at the rate of 100% of Covered Expenses unless otherwise indicated.

Covered Expenses are:

- Government Expenses: Charges for outpatient services, and for Physician services, provided by a United States Government Hospital, when required by federal law. Benefits are paid as if the services were provided by a non-government facility and covered under Medicare.
- Medical Supplies: Charges for any supply not covered under Medicare Part B because of a specific Medicare frequency or occurrence limitation, provided the supplier is permitted to charge for that supply.
- Nursing Services: Charges of a nurse (other than one who normally resides in your home or who is a member of your immediate family) for professional services. A member of your immediate family includes you, your spouse, and the children, brothers, sisters or parents of you or your spouse. Benefits are **at the rate of 80%** of Covered Expenses, and cannot exceed $5,000 per any one person in a calendar year. These services must meet the definition of a Covered Health Service (see Definitions). They cannot be for Custodial Care (see Definitions).
- Outpatient Physical and Occupational Therapy and Speech Pathology Services: Charges which would be payable under Medicare Part B except for the Medicare annual maximum benefit for these services.
- Physician's Services: Charges for any service or supply not covered by Medicare Part B because of a specific Medicare frequency or occurrence limitation, provided the Physician is permitted to charge for that service or supply.
- Transportation Services: Transportation services to or from a Hospital in your local area. If there are no local Hospitals that can provide the care needed, transportation service to the nearest Hospital outside your local area qualified to give the required treatment will be covered.

Medical Expense Benefit will be determined at all times as if the Person Eligible Under Medicare has Full Medicare Coverage (see Definitions).

EXCLUSIONS

Other exclusions that apply to this Benefit are in the General Exclusions section.

FOREIGN EMERGENCY CARE BENEFITS

The Plan covers a percentage of Emergency Medical Care Expenses incurred while on a trip outside the United States. The Expense is the actual cost to you for the Reasonable Charges (see Definitions) for the Covered Health Services (see Definitions) described below.

Emergency Medical Care Expenses are charges you incur for any care you receive while on a trip outside the United States. The care must be needed immediately for an injury or sickness which develops in a sudden and unexpected way during your trip. The care must be for services and supplies which would have been covered under the Hospital Expense Benefits or the Medical Expense Benefits if it had been provided in the United States. It must be received during the first 60 days of your trip.

PERCENTAGE OF EMERGENCY MEDICAL CARE EXPENSES PAYABLE

The Plan pays 80% on Emergency Medical Care Expenses in a calendar year. Payment will be made in United States currency in an amount based on the bank transfer exchange rate in effect on the day the claim is processed by UnitedHealthcare.

MAXIMUM AMOUNT

The Maximum Amount payable for you or any of your Dependents is $[25,000 - 200,000]. This Maximum Amount applies to a person's entire lifetime.

EXCLUSIONS

Emergency Medical Care Expense Benefits are not payable for any expenses that are eligible for payment under Medicare.

Emergency Medical Care Expense Benefits are not payable for any expense incurred after the first 60 days of any one trip outside the United States. One trip begins on the day you leave the United States and ends on the day you return to the United States.

Other Exclusions that apply to this Benefit are in the General Exclusions section.

AT-HOME RECOVERY CARE EXPENSE

The Plan covers At-Home Recovery Care Expenses incurred for at-home assistance on a short term basis for visits for Activities of Daily Living while you are recovering from an injury or sickness.

Activities of Daily Living are bathing, dressing, personal hygiene, transferring, eating, ambulating, assistance with drugs that are normally self-administered, and changing bandages or other dressings.

Payment will be made for up to $40 per visit, for up to 7 visits in any one week, and for up to $1,600 for you or any of your covered Dependents in any one calendar year. Each visit by a member of an at-home recovery team will be considered as one visit. Four hours of At-Home Recovery Care services will be considered as one visit. If a visit exceeds four hours, each additional four hours, or part thereof, in any one 24 hour period will count as one additional visit. Each visit by any other member of an at-home recovery team will count as an additional visit.

The following conditions must be met for each visit:

- Your Physician must certify that you need At-Home Recovery Care.
- You must have been approved for Home Health Services under Medicare for the same injury or sickness.
- The visit must occur during a Medicare approved period of Home Health Care, or within 8 weeks from your last Medicare approved Home Health Care visit.
- The visit is not paid for by Medicare or any other government program.
- The visit is not covered under the Medical Expense Benefits under the description of Nursing Services.
- The visit is provided by a Care Provider (see definition below).
- The visit is not provided by a member of your immediate family - comprising the Employee, the Employee's wife or husband, and the children, brothers, sisters and parents of either the Employee or the Employee's wife or husband.
- The visit is not provided by an unpaid volunteer.
- The visit occurs in your home. Your home is any place used by you as a place of residence, provided that such place would qualify as a residence for Home Health Care Services covered by Medicare. A Hospital or Skilled Nursing Facility would not be considered your home.

A Care Provider is a duly qualified or licensed Home Health Aide, Homemaker, Personal Care Aide or Nurse provided through a licensed home health care agency or referred by a licensed referral agency or licensed nurses registry.

A Home Health Aide, Homemaker or Personal Care Aide is a person who provides personal care services. If state or local licensing is required, the person must be licensed as a home health aide, homemaker or personal care aide where service is performed. If licensing is not required, any person who meets the minimum training qualifications recognized by the National Home Caring Council, National League of Nursing or Health Care Financing Administration will be considered a Home Health Aide, Homemaker or Personal Care Aide.

A Nurse is a professional nurse legally designated "RN" (Registered Nurse) or "LPN" (Licensed Practical Nurse) who, where licensing is required, holds a valid license from the state in which the nursing service is performed. "LPN" shall include a licensed vocational nurse ("LVN") and any other similarly designated nurse in those jurisdictions in which a professional nurse is designated as other than a "LPN", and for whom licensing is required.

EXCLUSIONS

Other Exclusions that apply to this Benefit are in the General Exclusions section.

PREVENTIVE MEDICAL CARE EXPENSE BENEFITS

The Plan covers Preventive Medical Care Expenses.

Preventive Medical Care Expenses are the following:

- An annual clinical preventive medical history and physical examination and patient education to address preventive health care measures.
- Any of the following preventive screening tests or preventive services approved by your Physician:
  - fecal occult blood test and/or digital rectal examination;
  - mammogram;
  - dipstick urinalysis for hematuria, bacteriuria and proteinuria;
  - pure tone (air only) hearing screening test;
  - serum cholesterol screening, but only once in every five year period;
  - thyroid function test;
  - diabetes screening;
  - prostate cancer screening;
  - colorectal cancer screening.
- Influenza vaccine administered at any appropriate time during the year.
- Tetanus and diphtheria booster once in every ten year period.
- Any other test or preventive measures determined appropriate by your Physician.

Benefits will be paid for the actual cost to you for the Reasonable Charges (see Definitions), up to $[100 – 2,000] in a calendar year for you or any of your Dependents.

EXCLUSIONS

Preventive Medical Care Expense Benefits are not payable for any service or supply covered by Medicare.

Other exclusions that apply to this Benefit are in the General Exclusions section.

TREATMENT CENTER EXPENSE BENEFITS

FOR ALCOHOLISM AND CHEMICAL DEPENDENCY

The Plan covers confinement of you or your covered Dependent in a Treatment Center because of alcoholism and/or chemical dependency when such dependency has been certified by a Physician or Psychologist and the confinement has been prescribed.

Payment will be made for the Reasonable Charges made by the Treatment Center for room, board, care and treatment for any one person, up to a calendar year maximum of 60 days.

Detoxification services will be covered for up to 12 days annually.

VIII

PLAN M

APPLICABLE TO PERSONS ELIGIBLE UNDER THE KEOLIS COMMUTER SERVICES (FORMERLY MBCR) EARLY RETIREMENT PLAN

Eligibility

This Plan has been developed to supplement the benefits for retired and disabled railroad Employees and their Dependents who qualify for coverage under the Keolis Commuter Services (formerly MBCR) Early Retirement Plan.

If you qualify for coverage under the Keolis Commuter Services (formerly MBCR) Early Retirement Plan you may enroll for Employee and/or Dependents benefits under Plan M provided your enrollment and payment are mailed (postmarked) to UnitedHealthcare on or before the last day of the month in which coverage under the Keolis Commuter Services (formerly MBCR) health plan for active employees terminates or in the next three calendar months.

When coverage for you or any family member terminates under the Keolis Commuter Services (formerly MBCR) Early Retirement Plan, you are no longer eligible for Plan M. You must notify UnitedHealthcare immediately when this occurs.

If you or a family member qualifies for Medicare due to age (65), your coverage under Plan M will be automatically transferred to Plan F.

If you or a family member becomes eligible for Medicare for any other reason you must notify UnitedHealthcare immediately.

MAJOR MEDICAL EXPENSE BENEFITS

The following benefits are payable only for services which are considered out-of-network under the Keolis Commuter Services (formerly MBCR) Early Retirement Plan or when the lifetime maximium under the Keolis Commuter Services (formerly MBCR) Early Retirement Plan has been exhausted. No benefits are payable under Plan M for In-network services.

PLAN M CLAIM DETERMINATIONS

Both the Cooperating Railway Labor Organizations, who are the policyholder under GA-23111, and UnitedHealthcare, desire a consistency in coverage under the Keolis Commuter Services (formerly MBCR) Early Retirement Plan and Plan M. However, there are some services covered under the Keolis Commuter Services (formerly MBCR) Early Retirement Plan which are not covered under Plan M. See the section entitled “Covered Services”.

The sections below entitled “Preferred Providers” and “Care Coordiantion” apply only when the lifetime maximum has been exhausted under the Keolis Commuter Services (formerly MBCR) Early Retirement Plan.

DEDUCTIBLE

The Deductible is separate for you and each of your Dependents each calendar year. It has two parts - a Basic Benefits Deductible and a Cash Deductible.

Basic Benefits Deductible

The Basic Benefits Deductible is the total payments made during the calendar year under the Keolis Commuter Services (formerly MBCR) Early Retirement Plan or, if the benefits under the Keolis Commuter Services (formerly MBCR) Early Retirement Plan are reduced in accordance with its Coordination of Benefits provisions, the payments which would have been made had such reduction not occurred.

Cash Deductible

The Cash Deductible is $[100 – 500].

PERCENTAGE OF COVERED EXPENSES PAYABLE

The Plan pays [60 – 80]% (75% for the first 40 outpatient visits for alcoholism, chemical dependency and/or mental illness, and 60% for any visits thereafter) of the Covered Expenses in a calendar year after the Deductible is satisfied.

The Plan pays 100% of the Covered Expenses in a calendar year after the Out-of-Pocket Maximum is met.

OUT-OF-POCKET MAXIMUM

The Out-of-Pocket Maximum limits the amount of Covered Expenses you will have to pay for any one covered individual in a calendar year. The Out-of-Pocket Maximum each calendar year is [$5,000 - $15,000]. Covered Expenses used to satisfy your Deductible are also used to help satisfy your Out-of-Pocket Maximum.

The following expenses do not count in determining if any Out-of-Pocket Maximum has been met:

- Charges you pay that are in excess of the Reasonable Charge.
- Charges you pay that are in excess of specific Plan limitations or exclusions.
- Charges you pay for expenses not covered by the Plan.
- The [$500 (or any part thereof)] reduction in benefits under the Keolis Commuter Services (formerly MBCR) Early Retirement Plan if the required notification is not made.
- Co-payments you make and any other charges you pay under the Keolis Commuter Services (formerly MBCR) Early Retirement Plan Managed Pharmacy Services Benefit.

MAXIMUM AMOUNT

The Maximum Amount payable with respect to you or any one of your Dependents is [$300,000 - $1,000,000]. This Maximum Amount applies to a person's entire lifetime.

COVERED EXPENSES

Covered Expenses are the actual cost to you of the Reasonable Charges (see Definitions) for the Covered Health Services (see Definitions) listed below. The service or supply must be needed because of injury, sickness or pregnancy.

A service or supply is not a Covered Health Service just because it is furnished by, or ordered by, your provider. The services and supplies will be reviewed by UnitedHealthcare to determine if they are covered under the Plan.

The services and supplies for which Covered Expenses may be incurred are as follows:

Ambulatory Surgical Center Services

Services given within 72 hours before or after a surgical procedure. The services have to be given in connection with the procedure.

Anesthetics

Applied Behavioral Analysis Services

Applied Behavioral Analysis (ABA) services for Autism Spectrum Disorders that are:

- Focused on the treatment of core deficits of Autism Spectrum Disorder;
- Provided by a *Board Certified Applied Behavioral Analyst (BCBA)* or other qualified provider under the appropriate supervision; and
- Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property, and impairment in daily functioning.
- Services include the following:
- Diagnostic evaluations, assessment and treatment planning.
- Treatment and/or procedures.
- Medication management and other associated treatments.
- Individual, family, and group therapy.
- Provider-based case management services.
- Crisis intervention.

Birth Center Services

Chemotherapy

Clinical Trials

Routine patient care costs incurred during participation in an approved clinical trial meeting the approved clinical trial criteria stated below.

Benefits include the reasonable and necessary items and services used to diagnose and treat complications arising from participation in an approved clinical trial.

Benefits are available only when the Covered Family Member is clinically eligible for participation in the clinical trial as defined by the researcher. Benefits are not available for preventive clinical trials.

Routine patient care costs for clinical trials include:

- Covered Health Services for which benefits are typically provided absent a clinical trial.
- Covered Health Services required solely for the provision of the investigational item or service, the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications.
- Covered Health Services needed for reasonable and necessary care arising from the provision of an investigational item or service.

Routine costs for clinical trials do not include:

- The Experimental or Investigational Service or item. The only exceptions to this are:
  - Certain Category B devices.
  - Certain promising interventions for patients with terminal illnesses.
  - Other items and services that meet specified criteria in accordance with our medical policy guidelines.
- Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.
- Items and services provided by the research sponsors free of charge for any person enrolled in the trial.

To be an approved clinical trial, a clinical trial must meet all of the following criteria:

- Be approved and funded in full or in part by one or more of the following:
  - National Institutes of Health (NIH). (Includes National Cancer Institute (NCI).)
  - Centers for Disease Control and Prevention (CDC).
  - Agency for Healthcare Research and Quality (AHRQ).
  - Centers for Medicare and Medicaid Services (CMS).
  - A bona fide clinical trial cooperative group, including the National Cancer Institute Clinical Trials Cooperative Group, the National Cancer Institute Community Clinical Oncology Program, the AIDS Clinical Trials Group, and the Community Programs for Clinical Research in AIDS.
  - The Department of Defense (DOD), the Department of Veterans Affairs, or the Department of Energy, or a qualified nongovernmental research entity to which the National Cancer Institute has awarded a support grant.
  - A study or investigation approved by the Food and Drug Administration (FDA), including those conducted under an investigational new drug or device application reviewed by the FDA.
  - An investigation or study approved by an Institutional Review Board registered with the Department of Health and Human Services that is associated with an institution that has a federal-wide assurance approved by the Department of Health and Human Services specifying compliance with federal regulations.
- The clinical trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (IRBs) before participants are enrolled in the trial. We may, at any time, request documentation about the trial to confirm that the clinical trial meets current standards for scientific merit and has the relevant IRB approvals.

The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Service and is not otherwise excluded under the Policy.

Durable Medical Equipment

Durable Medical Equipment means equipment that meets all of the following criteria:

- It is for repeated use and is not consumable or disposable
- It is used primarily for a medical purpose.
- It is appropriate for use in the home.

Some examples of durable medical equipment are:

- Appliances that replace a lost body organ or part or help an impaired one to work.
- Orthotic devices such as arm, leg, neck and back braces.
- Hospital-type beds.
- Equipment needed to increase mobility, such as a wheelchair.
- Respirators or other equipment for the use of oxygen.
- Monitoring devies.

Care Coordination must be contacted for any purchase or rental costs which exceed [$1,000]. Care Coordination will determine whether the purchase or rental of the equipment is Medically Appropriate.

Diabetes Treatment

Coverage for diabetic equipment, diabetes supplies and in-person outpatient diabetic self-management training and education programs (including medical nutrition therapy) when provided under the direction of a Physician by certified, registered or licensed health care professional.

Diabetes self-management training includes training provided to a Covered Person after the initial diagnosis in the care and management of that condition, including nutritional counseling and proper use of diabetes equipment and supplies. Coverage is also provided for additional training upon diagnosis of a significant change in medical condition that requires a change in the self-management regime, and a periodic continuing education training as warranted by the development of new techniques and treatment for diabetes.

Habilitative Services

Habilitative Services for children from birth to age 21 are covered, except for Habilitative Services provided in early intervention and school services.

Habilitative Services includes services, including occupational therapy, physical therapy, and speech therapy, for the treatment of a child with a congenital or genetic birth defect to enhance the child's ability to function. For purposes of Habilitaitive Services, a cogenital or genetic birth defect means a defect existing at or from birth, including a hereditary defect. A congential or genetic birth defect includes, but is not limited to (a) autism or autism spectrum disorder, and (b) cerebral palsy.

Home Health Care Agency Services

- Part-time or intermittent nursing care rendered by or supervised by a registered nurse.
- Part-time or intermittent care by a home health aide.

- Physical therapy or occupational therapy.
- Speech therapy to restore speech lost or impaired due to removal of vocal cords, cerebral thrombosis, or brain damage due to injury or organic brain lesion.
- Prescription drugs
- Medical Supplies.
- X-rays and laboratory tests.

Hospice Care Services

Up to a maximum payment of [$3,000] for each Course of Care for room, board, care and treatment charged by a Hospice.

Up to a maximum payment of [$1,000] for each Course of Care for:

- Counseling for the patient's Immediate Family. Services must be given by a licensed social worker or a licensed pastoral counselor.
- Bereavement counseling up to [15] visits for the patient's Immediate Family. Services must be given by a licensed social worker or a licensed pastoral counselor and given within six months after the patient's death.

The Physician must certify that the patient is terminally ill with 6 months or less to live.

"Immediate Family" means you or any member of your family who is covered under this Plan.

"Course of Care" means all services given to the patient and the patient's Immediate Family in connection with the terminal illness of the patient.

Services provided by a licensed pastoral counselor to a member of his/her congregation in the course of his/her normal duties as a pastor or minister will not be considered a Covered Expense.

Hospital Services

Services and supplies provided by a Hospital on an inpatient or outpatient basis.

If charges are made for a private room, Covered Expenses will be limited to the hospital's average daily charge for a semi-private room.

Coverage is also provided for up to 60 inpatient days per calendar year for alcoholism, chemical dependency and/or mental illness services. In addition, coverage is provided for up to 12 days per calendar year for inpatient detoxification services.

Coverage is also provided for newborn infant hearing screenings and all necessary audiological examinations provided as recommended by the National Joint Committee on Infant Hearing. For purposes of this coverage, "Hospital" shall include birthing centers or other centers having newborn nurseries.

Services and supplies provided by a Hospital for emergency care and treatment for a medical emergency, including the sudden onset or worsening of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent lay person, who possesses an average knowledge of health and medicine to result in:

- Placing the patient's health in serious jeopardy;
- Serious impairment to bodily functions; or

- Serious dsyfunction of any bodily organ or part.

Coverage is also provided for a voluntary HIV screening test performed while receiving emergency care in a Hospital, once per calendar year, regardless of whether or not the HIV screening is necessary for the treatment of the condition for which the emergency care is sought.

Infertility Treatment

Diagnosis and treatment of infertility, including surgery and drug therapy. This does not include procedures or services to facilitate a pregnancy, such as, but not limited to, in vitro fertilization, embryo transfer, artificial insemination and immunotherapy for infertility.

Medical Supplies

- Surgical supplies (such as bandages and dressings). Supplies given during surgery or a diagnostic procedure are included in the overall cost for that surgery or diagnostic procedure.
- Blood or blood plasma only if not donated or replaced.

Nursing Services

Services of a trained nurse or a Nurse-Midwife.

Occupational Therapy

Services of a licensed occupational therapist provided the following conditions are met:

- The therapy must be ordered and monitored by a Physician.
- The therapy must be given in accordance with a written treatment plan approved by a Physician. The therapist must submit progress reports to the Physician at the intervals stated in the treatment plan.
- The therapy must be expected to result in significant, objective, measurable physical improvement within two (2) months of the start of treatment.

Organ/Tissue Transplants

- Donor Charges

  In the case of an organ or tissue transplant, no services or supplies for the donor are considered Covered Health Services unless the recipient is the Employee or his/her Dependent. If the recipient is not the Employee or his/her Dependent, no benefits are payable for donor charges.

  The search for bone marrow/stem cell from a donor who is not biologically related to the patient is not considered a Covered Health Service UNLESS the search is made in connection with a transplant procedure arranged by a Transplant Facility.

- Qualified Procedures

  If a qualified procedure, listed below, is Medically Appropriate, the “Medical Care and Treatment” provisions set forth below apply:

  - Heart transplants
  - Heart/lung transplants
  - Liver transplants
  - Kidney transplants
  - Pancreas transplants
  - Kidney/pancreas transplants

- Bone marrow/stem cell transplants
- Other transplant procedures when UnitedHealthcare determines that it is necessary to perform the procedure at a Treatment Facility.

- Medical Care and Treatment
  - The following services provided in connection with the transplant are Covered Health Services:
    - Pre-transplant evaluation for one of the procedures listed above
    - Organ acquisition and procurement
    - Hospital and Physician fees
    - Transplant procedures
    - Follow-up care for a period up to one year after the transplant
    - Search for bone marrow/stem cell from a donor who is not biologically related to the patient. If a separate charge is made for a bone marrow/stem cell search, a maximum benefit of $25,000 is payable for all charges made in connection with the search.

- Transportation and Lodging

  The following benefits for transportation and lodging expenses are available for those Medically Appropriate Qualified Procedures, as listed above, that are performed at a Transplant Facility. If a Transplant Facility is not used, then these transportation and lodging benefits will not be covered.

  Care Coordination will assist the patient and family with travel and lodging arrangements. Expenses for travel, lodging and meals for the transplant recipient and a companion are available under this Plan as follows:

  - Reasonable and necessary expenses for transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of the transplant for the purposes of an evaluation, the transplant procedure or necessary post-discharge follow-up.
  - Reasonable and necessary expenses for lodging and meals for the patient (while not confined) and one companion. Benefits are paid at a per diem rate of up to $50 for one person or up to $100 for two people.

  Travel and lodging expenses are only available if the transplant recipient resides more than 50 miles from the Transplant Facility.

  If the Dependent who is the patient is a minor child, the transportation expenses of two companions will be covered and lodging and meal expenses will be reimbursed up to the $100 per diem rate.

  There is a combined overall lifetime maximum of $10,000 per Employee or Dependent for all transportation, lodging and meal expenses incurred by the transplant recipient and companion(s) and reimbursed under this Plan M [and Plans A, B and/or C, combined], in connection with all transplant procedures.

Outpatient Alcholism, Chemical Dependency and Mental Illness Services

Benefits for outpatient services to treat alcoholism, chemical dependency and/or mental illness. The Plan pays 75% of the Covered Expenses in a calendar year after the Deductible is satisfied, for the first 40 outpatient visits, and then 60% of any additional visits.

Physical Therapy

Services of a licensed physical therapist, provided the following conditions are met:

- The therapy must be ordered and monitored by a Physician.
- The therapy must be given in accordance with a written treatment plan approved by a Physician.
- The therapist must submit progress reports to the Physician at the intervals stated in the treatment plan.

The therapy must be expected to result in significant, objective, measurable physical improvement within two months of the start of the treatment.

In addition, benefits for physical therapy for Dependent children, under the age of 21, with congenital or birth defects (including autism and cerebral palsy) will be covered.

Physicians Services

Prescription Contraceptive Devises

Devices approved by the U.S. Food and Drug Administration for the prevention of a pregnancy are covered for female employees and the wives of male employees.

Prescription Drugs

Prescription Drugs other than those obtained from a retail pharmacy or by mail order.

Preventive Adult Health Services

- Benefits are available for mammography testing that is consistent with the recommendations of governmental scientific agencies. Benefits for mammography testing are payable when mammography testing is performed as follows:
    - a baseline mammogram; and
    - follow-up mammograms on an annual basis.
- Pap smears are covered annually, or when it is determined by the attending physician that the test is necessary.

The preventive services listed above are not subject to coinsurance or the Calendar Year Deductible.

- Colorectal cancer screenings are covered in compliance with the American Cancer Society colorectal cancer screenings guidelines.
- Screenings in accordance with the latest screening guidelines issued by the American Cancer Society.

Preventive Child Health Services

Benefits are available from birth to age 21 including:

- Coverage for injury or sickness, including the necessary care and treatment of medically diagnosed congenital defects, birth abnormalities, and prematurity; and
- Coverage for preventive and primary care services, including physician examinations, measurements, sensory screening, neuropsychiatric evaluation, and development screening, which coverage shall include unlimited visits up to the age of 12 years, and 3 visits per year for minor children ages 12 years up to age 21 years of age. Preventive and primary care services shall also include, as recommended by the physician, hereditary and metabolic screening at birth, immunizations, urinalysis, tuberculin tests, and hematocrit, hemoglobin, and other appropriate blood tests, including tests to screen for sickle hemoglobinopathy.

Psychologist Services

Radiation Therapy

Skilled Nursing Facility Care After Hospital Confinement

Services and supplies up to 31 days of confinement following each Hospital confinement.

Separate confinements for the same cause are considered to be one confinement, unless separated by 14 or more days.

If charges are made for a private room, Covered Expenses will be limited to the facility's daily charge for a semi-private room.

Speech Therapy

These services must be given to restore speech. The speech must have been lost or impaired due to one of the following:

- Removal of vocal cords.
- Cerebral thrombosis (cerebral vascular accident).
- Brain damage due to injury or organic brain lesion (aphasia).

The therapy must be expected to result in significant, objective, measurable physical improvement within two months of the start of the treatment.

In addition, benefits for speech therapy for Dependent children, under the age of 21, with congenital or birth defects (including autism and cerebral palsy) will be covered.

Spinal Manipulations

Services of a physician given for the detection or correction (manipulation) by manual ormechanical means of structural imbalance or distortion in the spine.

No benefits are available for any type of therapy, service or supply, including, but not limited to, spinal manipulation by a chiropractor or other physician once the therapy, service or supply ceases to be therapeutic and is instead administered to maintain a level of functioning or to prevent a medical problem from occuring or reoccuring.

Telehealth

Charges for services provided through telehealth rather than face-to-face consultation when the services can appropriately be provided through telehealth.

- "Telehealth" means the use of live, interactive audio and visual transmissions of a physician-patient encounter from one site to another using telecommunications technologies. They may include transmissions of real-time telecommunications or those transmitted by store-and-forward technology.

- Telemedicine services are medical services provided via ~~telephone, the Internet, or other communications networks or devices~~ interactive audio, video or other electronic media for the purpose of diagnosis, consultation, or treatment that do not involve direct, in-person patient contact.

Treatment Center Services

Charges for services at a Treatment Center when a Physician or Psychologist has certified an alcoholism or chemical dependency and has prescribed such services, up to a calendar year maximum of 60 days. In addition, detoxification services will be covered for up to 12 days annually.

Transportation Services

Transportation charges are covered for transportation to a Hospital in an emergency.

The transportation services must be to a Hospital in your local area. If there are no local Hospitals that can provide the care needed, charges for transportation to the nearest Hospital outside your local area qualified to give the required treatment, will be covered.

X-ray and Laboratory Tests

EXCLUSIONS

Major Medical Expenses Benefits are not payable for expenses for:

- Expenses for any confinement, treatment, services or supplies which would have been payable under the Keolis Commuter Services (formerly MBCR) Early Retirement Plan, but which were not payable due to you or your Dependent's non-compliance with the medical management provisions described under the Keolis Commuter Services (formerly MBCR) Early Retirement Plan.

- Prescription Drugs purchased from a pharmacy or by mail order.

Other exclusions that apply to this Benefit are in the General Exclusions section.

PREFERRED PROVIDERS

UnitedHealthcare has arranged with certain health care providers to become Preferred Providers. These Preferred Providers have agreed to discount their charges for Covered Expenses.

If Preferred Providers are used, the amount of Covered Expenses for which you are responsible will generally be less than the amount owed if other providers had been used. The percentage of Covered Expenses payable remains the same whether or not Preferred Providers are used. However, because the Covered Expenses may be less when Preferred Providers are used, the portion that you owe will be less.

You will receive an Identification Card showing that you and/or your Dependents covered under Plan M are entitled to these discounts. This Identification Card must be shown every time health care services are given. This is how the provider knows that you and/or your Dependent is covered under a Preferred Provider plan. Otherwise, you could be billed for the provider's normal charge.

Call UnitedHealthcare at 1-800-842-5252 to inquire about or locate Preferred Providers in your area. You may also access Preferred Provider information online at myuch.com.

Preferred Providers are responsible for filing your claims directly to UnitedHealthcare. You do not need to submit claims for Preferred Providers services or supplies.

You must submit claims for services and supplies rendered by other providers as described in the Claim Information section.

If a Preferred Provider bills you for any part of the discount amount, call UnitedHealthcare at 1-800-842-5252 for assistance.

CARE COORDINATION

Notification

UnitedHealthcare's Care Coordination must be contacted for the following services:

- Inpatient facility admissions
- Reconstructive procedures
- Maternity Services (if stay exceeds the 48/96 guidelines)
- Transplant services
- [Gender transformation surgery]

How to Notify Care Coordination

Care Coordination is notified by calling toll-free 1-800-842-4555. Their working days are Monday through Friday, except for State and Federal holidays. The hours of operation are 8:00 a.m. to 7:00 p.m. However, you can call Care Coordination at any time, day, or night. If you call outside the hours of operation, you may leave a message with your telephone number on an answering machine, and a Care Coordination representative will return your call within one working day.

When to Notify Care Coordination

Care Coordination should be notified as promptly as possible before any of the services listed above are rendered. The notification allows Care Coordination sufficient time to complete a review before the services are rendered. Otherwise, if Care Coordination does not receive sufficient advance notice, they may not be able to complete the review before you incur expenses.

For an emergency which results in a confinement, you (or a representative or your Physician) must call Care Coordination within two days (excluding weekends and holidays) of the date the confinement begins.

You should notify Care Coordination promptly after you become aware that you are pregnant. You must notify Care Coordination only if the inpatient care for the mother or child is expected to continue beyond:

- 48 hours following a normal vaginal delivery, or
- 96 hours following a cesarean section.

What Care Coordination Does

Care Coordination reviews the services you are to receive with your Physician, and agrees on a treatment plan. If there is disagreement between Care Coordination and your Physician, a Care Coordination Physician Advisor may be involved.

If there is still not agreement on a treatment plan, you and your Physician always make the final decision.

Effect on Benefits

If Care Coordination is not notified when required, benefits otherwise payable at 70% will be paid at 60%. If your Out-of-Pocket Maximum has been met, the Plan will pay 100% of Covered Expenses even if Care Coordination is not notified. If your benefits are reduced from 70% to 60% because Care Coordination is not notified when required, the full 40% you pay will be applied to your Out-of-Pocket Maximum.

The Plan pays a percentage of Covered Expenses incurred in calendar year which exceed the Deductible.

Remember: This notice obligation is your responsibility. It is not the responsibility of your Physician, your Hospital, or any other provider to make the required notification to Care Coordination. However, your Physician, Hospital, or other provider may make this notice for you.

Other exclusions that apply to this Benefit are in the General Exclusions section.

IX

PLAN P

APPLICABLE TO PERSONS ELIGIBLE UNDER THE AMTRAK EARLY RETIREMENT PLAN AND THE TRANSITAMERICA SERVICES, INC. (TASI) EARLY RETIREMENT PLAN

ELIGIBILILTY

This Plan has been developed to supplement the benefits for retired and disabled railroad Employees and their Dependents who qualify for coverage under the Amtrak Early Retirement Plan or the TransitAmerica Services, Inc. (TASI) Early Retirement Plan.

If you qualify for coverage under the Amtrak Early Retirement Plan or the TransitAmerica Services, Inc. (TASI) Early Retirement Plan, you may enroll for Employee and/or Dependent benefits under Plan P provided your enrollment and payment are mailed (postmarked) to UnitedHealthcare on or before the last day of the month in which coverage under the Amtrak Early Retirement Plan or TransitAmerica Services, Inc. (TASI) Plan terminates or in the next three calendar months.

When coverage for you or any family member terminates under the Amtrak Early Retirement Plan or the TransitAmerica Services, Inc. (TASI) Early Retirement Plan, you are no longer eligible for Plan P. You must notify UnitedHealthcare immediately when this occurs.

If you or a family member qualifies for Medicare due to age (65), your coverage under Plan P will be automatically transferred to Plan F.

If you or a family member becomes eligible for Medicare for any other reason, you must notify UnitedHealthcare immediately.

MAJOR MEDICAL EXPENSE BENEFITS

The Plan pays [60% - 80%] (75% for the first 40 outpatient visits for alcoholism, chemical dependency and/or mental illness and 60% for any visits thereafter) of the Covered Expenses incurred in a calendar year which exceed the Deductible.

DEDUCTIBLE

The Deductible is separate for you and each of your Dependents each calendar year. It has two parts - a Basic Benefits Deductible and a Cash Deductible.

Basic Benefits Deductible

The Basic Benefits Deductible is the total payments made during the calendar year under the Amtrak Early Retirement Plan or the TransitAmerica Services, Inc. Plan or, if the benefits under the Amtrak Early Retirement Plan or the TransitAmerica Services, Inc. (TASI) Early Retirement Plan are reduced in accordance with its Coordination of Benefits provisions, the payments which would have been made had such reduction not occurred.

Cash Deductible

The Cash Deductible is $[100 – 500].

PERCENTAGE OF COVERED EXPENSES PAYABLE

The Plan pays [60–80]% (75% for the first 40 outpatient visits for alcoholism, chemical dependency and/or mental illness and 60% for any visits thereafter) of Covered Expenses in a calendar year after the Deductible is satisfied.

The Plan pays 100% of the Covered Expenses in a calendar year after the Out-of-Pocket Maximum is met.

OUT-OF-POCKET MAXIMUM

The Out-of-Pocket Maximum limits the amount of Covered Expenses you will have to pay for any one covered individual in a calendar year. The Out-of-Pocket Maximum each calendar year is $[5,000 – 15,000]. Covered Expenses used to satisfy your Deductible are also used to help satisfy your Out-of-Pocket Maximum.

The following expenses do not count in determining if any Out-of-Pocket Maximum has been met:

- Charges you pay that are in excess of the Reasonable Charge.
- Charges you pay that are in excess of specific Plan limitations or exclusions.
- Charges you pay for expenses not covered by the Plan.
- Charges you pay as a result of a reduction in benefits under the Amtrak Early Retirement Plan or the TransitAmerica Services, Inc. (TASI) Early Retirement Plan if any required medical management notification is not made, or if medical management determines that the service or supply is not a Covered Health Service as that term is defined under the Amtrak Early Retirement Plan or the TransitAmerica Services, Inc. (TASI) Early Retirement Plan.
- Co-payments you make and any other charges you pay under the Amtrak Early Retirement Plan or the TransitAmerica Services, Inc. (TASI) Early Retirement Plan prescription drug benefit.

MAXIMUM AMOUNT

The Maximum Amount payable with respect to you or any one of your Dependents is $[300,000 – 1,000,000]. This Maximum Amount applies to a person's entire lifetime.

COVERED EXPENSES

Covered Expenses are the actual cost to you of the Reasonable Charges (see Definitions) for the Covered Health Services (see Definitions) listed below. The service or supply must be needed because of injury, sickness or pregnancy.

A service or supply is not a Covered Health Service just because it is furnished by, or ordered by, your provider. The services and supplies will be reviewed by UnitedHealthcare to determine if they are covered under the Plan.

The services and supplies for which Covered Expenses may be incurred are as follows:

Ambulatory Surgical Center Services

Services given within 72 hours before or after a surgical procedure. The services have to be given in connection with the procedure.

Anesthetics

Applied Behavioral Analysis Services

Applied Behavioral Analysis (ABA) services for Autism Spectrum Disorders that are:

- Focused on the treatment of core deficits of Autism Spectrum Disorder;
- Provided by a *Board Certified Applied Behavioral Analyst (BCBA)* or other qualified provider under the appropriate supervision; and
- Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property, and impairment in daily functioning.
- Services include the following:
- Diagnostic evaluations, assessment and treatment planning.
- Treatment and/or procedures.
- Medication management and other associated treatments.
- Individual, family, and group therapy.
- Provider-based case management services.
- Crisis intervention.

Birth Center Services

Chemotherapy

Clinical Trials

Routine patient care costs incurred during participation in an approved clinical trial meeting the approved clinical trial criteria stated below.

Benefits include the reasonable and necessary items and services used to diagnose and treat complications arising from participation in an approved clinical trial.

Benefits are available only when the Covered Family Member is clinically eligible for participation in the clinical trial as defined by the researcher. Benefits are not available for preventive clinical trials.

Routine patient care costs for clinical trials include:

- Covered Health Services for which benefits are typically provided absent a clinical trial.
- Covered Health Services required solely for the provision of the investigational item or service, the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications.
- Covered Health Services needed for reasonable and necessary care arising from the provision of an investigational item or service.

Routine costs for clinical trials do not include:

- The Experimental or Investigational Service or item. The only exceptions to this are:
  - Certain Category B devices.
  - Certain promising interventions for patients with terminal illnesses.
  - Other items and services that meet specified criteria in accordance with our medical policy guidelines.
- Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.
- Items and services provided by the research sponsors free of charge for any person enrolled in the trial.

To be an approved clinical trial, a clinical trial must meet all of the following criteria:

- Be approved and funded in full or in part by one or more of the following:
  - National Institutes of Health (NIH). (Includes National Cancer Institute (NCI).)
  - Centers for Disease Control and Prevention (CDC).
  - Agency for Healthcare Research and Quality (AHRQ).
  - Centers for Medicare and Medicaid Services (CMS).
  - A bona fide clinical trial cooperative group, including the National Cancer Institute Clinical Trials Cooperative Group, the National Cancer Institute Community Clinical Oncology Program, the AIDS Clinical Trials Group, and the Community Programs for Clinical Research in AIDS.
  - The Department of Defense (DOD), the Department of Veterans Affairs, or the Department of Energy, or a qualified nongovernmental research entity to which the National Cancer Institute has awarded a support grant.
  - A study or investigation approved by the Food and Drug Administration (FDA), including those conducted under an investigational new drug or device application reviewed by the FDA.
  - An investigation or study approved by an Institutional Review Board registered with the Department of Health and Human Services that is associated with an institution that has a federal-wide assurance approved by the Department of Health and Human Services specifying compliance with federal regulations.
- The clinical trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (IRBs) before participants are enrolled in the trial. We may, at any time, request documentation about the trial to confirm that the clinical trial meets current standards for scientific merit and has the relevant IRB approvals.

The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Service and is not otherwise excluded under the Policy.

Diabetes Treatment

Coverage for diabetic equipment, diabetes supplies and in-person outpatient diabetic self-management training and education programs (including medical nutrition therapy) when provided under the direction of a Physician by a certified, registered or licensed health care professional.

Diabetes self-management training includes training provided to a Covered Person after the initial diagnosis in the care and management of that condition, including nutritional counseling and proper use of diabetes equipment and supplies. Coverage is also provided for additional training upon diagnosis of a significant change in medical condition that requires a change in the self-management regime, and a periodic continuing education training as warranted by the development of new techniques and treatment for diabetes.

Durable Medical Equipment

Durable Medical Equipment means equipment that meets all of the following criteria:

- It is for repeated use and is not consumable or disposable.
- It is used primarily for a medical purpose.
- It is appropriate for use in the home.

Some examples of durable medical equipment are:

- Appliances that replace a lost body organ or part or help an impaired one to work.
- Orthotic devices such as arm, leg, neck and back braces.
- Hospital-type beds.
- Equipment needed to increase mobility, such as a wheelchair.
- Respirators or other equipment for the use of oxygen.
- Monitoring devices.

Care Coordination must be contacted for any purchase or rental costs which exceed [$1,000]. Care Coordination will determine whether the purchase or rental of the equipment is Medically Appropriate.

Habilitative Services

Habilitative Services for children from birth to age 21 are covered, except for Habilitative Services provided in early intervention and school services.

Habilitative Services includes services, including occupational therapy, physical therapy, and speech therapy, for the treatment of a child with a congenital or genetic birth defect to enhance the child's ability to function. For purposes of Habilitaitive Services, a cogenital or genetic birth defect means a defect existing at or from birth, including a hereditary defect. A congential or genetic birth defect includes, but is not limited to (a) autism or autism spectrum disorder, and (b) cerebral palsy.

Home Health Care Agency Services

- Part-time or intermittent nursing care rendered by or supervised by a registered nurse.
- Part-time or intermittent care by a home health aide.
- Physical therapy or occupational therapy.
- Speech therapy to restore speech lost or impaired due to removal of vocal cords, cerebral thrombosis, or brain damage due to injury or organic brain lesion.
- Prescription Drugs.
- Medical Supplies.
- X-rays and laboratory tests.

Hospice Care Services

Up to a maximum payment of [$3,000] for each Course of Care for room, board, care and treatment charged by a Hospice.

Up to a maximum payment of [$1,000] for each Course of Care for:

- Counseling for the patient's Immediate Family. Services must be given by a licensed social worker or a licensed pastoral counselor.
- Bereavement counseling up to [15] visits for the patient's Immediate Family. Services must be given by a licensed social worker or a licensed pastoral counselor and given within six months after the patient's death.

The Physician must certify that the patient is terminally ill with 6 months or less to live.

"Immediate Family" means you or any member of your family who is covered under this Plan.

"Course of Care" means all services given to the patient and the patient's Immediate Family in connection with the terminal illness of the patient.

Services provided by a licensed pastoral counselor to a member of his/her congregation in the course of his/her normal duties as a pastor or minister will not be considered a Covered Expense.

Hospital Services

Services and supplies provided by a Hospital on an inpatient or outpatient basis.

If charges are made for a private room, Covered Expenses will be limited to the hospital's average daily charge for a semi-private room.

Coverage is also provided for up to 60 inpatient days per calendar year for alcoholism, chemical dependency and/or mental illness services. In addition, coverage is provided for up to 12 days per calendar year for inpatient detoxification services.

Coverage is also provided for newborn infant hearing screenings and all necessary audiological examinations provided as recommended by the National Joint Committee on Infant Hearing. For purposes of this coverage, "Hospital" shall include birthing centers or other centers having newborn nurseries.

Services and supplies provided by a Hospital for emergency care and treatment for a medical emergency, including the sudden onset or worsening of a medical condition that manifests itself by

symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent lay person, who possesses an average knowledge of health and medicine to result in:

- Placing the patient's health in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dsyfunction of any bodily organ or part.

Coverage is also provided for the cost of a voluntary HIV screening test performed while receiving emergency care in a Hospital, once per calendar year, regardless of whether or not the HIV screening is necessary for the treatment of the condition for which the emergency care is sought.

Infertility Treatment

Diagnosis and treatment of infertility, including surgery and drug therapy. This does not include procedures or services to facilitate a pregnancy, such as, but not limited to, in vitro fertilization, embryo transfer, artificial insemination and immunotherapy for infertility.

Medical Supplies

- Surgical supplies (such as bandages and dressings). Supplies given during surgery or a diagnostic procedure are included in the overall cost for that surgery or diagnostic procedure.
- Blood or blood plasma only if not donated or replaced.

Nursing Services

Services of a trained nurse or a Nurse-Midwife.

Occupational Therapy

Services of a licensed occupational therapist provided the following conditions are met:

- The therapy must be ordered and monitored by a Physician.
- The therapy must be given in accordance with a written treatment plan approved by a Physician. The therapist must submit progress reports to the Physician at the intervals stated in the treatment plan.
- The therapy must be expected to result in significant, objective, measurable physical improvement within 2 months of the start of treatment.

Organ/Tissue Transplants

- Donor Charges

  In the case of an organ or tissue transplant, no services or supplies for the donor are considered Covered Health Services unless the recipient is the Employee or his/her Dependent. If the recipient is not the Employee or his/her Dependent, no benefits are payable for donor charges.

  The search for bone marrow/stem cell from a donor who is not biologically related to the patient is not considered a Covered Health Service UNLESS the search is made in connection with a transplant procedure arranged by a Transplant Facility.

- Qualified Procedures

  If a qualified procedure, listed below, is Medically Appropriate, the "Medical Care and Treatment" provisions set forth below apply:

  - Heart transplants

- Heart/lung transplants
- Liver transplants
- Kidney transplants
- Pancreas transplants
- Kidney/pancreas transplants
- Bone marrow/stem cell transplants
- Other transplant procedures when UnitedHealthcare determines that it is necessary to perform the procedure at a Treatment Facility.

- Medical Care and Treatment
  - The following services provided in connection with the transplant are Covered Health Services:
    - Pre-transplant evaluation for one of the procedures listed above
    - Organ acquisition and procurement
    - Hospital and Physician fees
    - Transplant procedures
    - Follow-up care for a period up to one year after the transplant
    - Search for bone marrow/stem cell from a donor who is not biologically related to the patient. If a separate charge is made for a bone marrow/stem cell search, a maximum benefit of $25,000 is payable for all charges made in connection with the search.

- Transportation and Lodging

  The following benefits for transportation and lodging expenses are available for those Medically Appropriate Qualified Procedures, as listed above, that are performed at a Transplant Facility. If a Transplant Facility is not used, then these transportation and lodging benefits will not be covered.

  Care Coordination will assist the patient and family with travel and lodging arrangements. Expenses for travel, lodging and meals for the transplant recipient and a companion are available under this Plan as follows:

  - Reasonable and necessary expenses for transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of the transplant for the purposes of an evaluation, the transplant procedure or necessary post-discharge follow-up.
  - Reasonable and necessary expenses for lodging and meals for the patient (while not confined) and one companion. Benefits are paid at a per diem rate of up to $50 for one person or up to $100 for two people.

  Travel and lodging expenses are only available if the transplant recipient resides more than 50 miles from the Transplant Facility.

  If the Dependent who is the patient is a minor child, the transportation expenses of two companions will be covered and lodging and meal expenses will be reimbursed up to the $100 per diem rate.

  There is a combined overall lifetime maximum of $10,000 per Employee or Dependent for all transportation, lodging and meal expenses incurred by the transplant recipient and companion(s) and reimbursed under this Plan P [and Plans A, B and/or C, combined], in connection with all transplant procedures.

Outpatient Alcoholism, Chemical Dependency and Mental Illness Services

Benefits for outpatient services to treat alcoholism, chemical dependency and/or mental illness. The Plan pays 75% of the Covered Expenses in a calendar year after the Deductible is satisfied for the first 40 outpatient visits for alcoholism, chemical dependency and/or mental illness, and then 60% of any additional visits.

Physical Therapy

Services of a licensed physical therapist, provided the following conditions are met:

- The therapy must be ordered and monitored by a Physician.
- The therapy must be given in accordance with a written treatment plan approved by a Physician.
- The therapist must submit progress reports to the Physician at the intervals stated in the treatment plan.

The therapy must be expected to result in significant, objective, measurable physical improvement within two months of the start of the treatment.

Physicians Services

Prescription Drugs

Prescription drugs other than those obtained from a retail pharmacy or by mail order.

Prescription Contraceptive Devices

Devices approved by the U.S. Food and Drug Administration for the prevention of a pregnancy are covered for female employees and the wives of male employees.

Preventive Adult Health Services

- Benefits are available for mammography testing that is consistent with the recommendations of governmental scientific agencies. Benefits for mammography testing are payable when mammography testing is performed as follows:
    - a baseline mammogram; and
    - follow-up mammograms on an annual basis.
- Pap smears are covered annually, or when it is determined by the attending physician that the test is necessary.

The preventive services listed above are not subject to coinsurance or the calendar year Deductible.

- Colorectal cancer screenings are covered in compliance with the American Cancer Society colorectal cancer screenings guidelines.
- Screenings in accordance with the latest screening guidelines issued by the American Cancer Society.

Preventive Child Health Services

Benefits are available from birth to age 21 including:

- Coverage for injury or sickness, including the necessary care and treatment of medically diagnosed congenital defects, birth abnormalities, and prematurity; and
- Coverage for preventive and primary care services, including physician examinations, measurements, sensory screening, neuropsychiatric evaluation, and development screening, which coverage shall include unlimited visits up to the age of 12 years, and 3 visits per year for minor children ages 12 years up to age 21 years of age. Preventive and primary care services shall also include, as recommended by the physician, hereditary and metabolic screening at birth, immunizations, urinalysis, tuberculin tests, and hematocrit, hemoglobin, and other appropriate blood tests, including tests to screen for sickle hemoglobinopathy.

Psychologist Services

Radiation Therapy

Rehabilitative Services

Benefits for occupational therapy, speech therapy and physical therapy for Dependent children, under the age of 21, with congenital or birth defects (including autism and cerebral palsy).

Skilled Nursing Facility Care After Hospital Confinement

Services and supplies up to 31 days of confinement following each Hospital confinement.

Separate confinements for the same cause are considered to be one confinement, unless separated by 14 or more days.

If charges are made for a private room, Covered Expenses will be limited to the facility's daily charge for a semi-private room.

Speech Therapy

These services must be given to restore speech. The speech must have been lost or impaired due to one of the following:

- Removal of vocal cords.
- Cerebral thrombosis (cerebral vascular accident).
- Brain damage due to injury or organic brain lesion (aphasia).

The therapy must be expected to result in significant, objective, measurable physical improvement within two months of the start of the treatment.

Spinal Manipulations

Services of a physician given for the detection or correction (manipulation) by manual or mechanical means of structural imbalance or distortion in the spine.

No benefits are available for any type of therapy, service or supply, including, but not limited to, spinal manipulation by a chiropractor or other phsycian once the therapy, service or supply ceases to be therapeutic and is instead administered to maintain a level of functioning or to prevent a medical problem from occuring or reoccurring.

Telehealth

Charges for services provided through telehealth rather than face-to-face consultation when the services can appropriately be provided through telehealth.

- "Telehealth" means the use of live, interactive audio and visual transmissions of a physician-patient encounter from one site to another using telecommunications technologies. They may include transmissions of real-time telecommunications or those transmitted by store-and-forward technology.

- Telemedicine services are medical services provided via ~~telephone, the Internet, or other communications networks or devices~~ interactive audio, video or other electronic media for the purpose of diagnosis, consultation, or treatment that do not involve direct, in-person patient contact.

Transportation Services

Transportation charges are covered for transportation to a Hospital in an emergency.

The transportation services must be to a Hospital in your local area. If there are no local Hospitals that can provide the care needed, charges for transportation to the nearest Hospital outside your local area qualified to give the required treatment, will be covered.

Treatment Center Services

Charges for services at a Treatment Center when a Physician or Psychologist has certified an alcoholism or chemical dependency and has prescribed such services, up to a calendar year maximum of 60 days. In addition, detoxification services will be covered for up to 12 days annually.

X-ray and Laboratory Tests

EXCLUSIONS

Major Medical Expenses Benefits are not payable for expenses for:

- Expenses for any confinement, treatment, services or supplies which would have been payable under the Amtrak Early Retirement Plan or the TransitAmerica Services, Inc. Early Retirement Plan, but which were not payable due to you or your Dependent's non-compliance with any required medical management provisions described under the Amtrak Early Retirement Plan or the TransitAmerica Services, Inc. Early Retirement Plan.
- Prescription Drugs purchased from a pharmacy or by mail order.
- ~~Expenses for treatment of on-duty injuries if the railroad has paid those expenses.~~

Other exclusions that apply to this Benefit are in the General Exclusions section.

IX

GENERAL EXCLUSIONS

This Plan does not cover any expenses incurred for services, supplies, medical care or treatment relating to, arising out of, or given in connection with the following, even if recommended or prescribed by a Physician or is the only treatment available for your condition:

- Dependent who is covered as an Employee for the same services under this Plan.
- A Dependent who is covered as an Employee under any Hospital Association Plan.
- Dependent child's pregnancy or the resulting childbirth, adoption or miscarriage.
- Dependents' Work Related Injury or Sickness - services or supplies for which your Eligible Dependent is entitled to indemnity under any workers' compensation or similar law.
- Service or supplies received before an Employee or his or her Dependent becomes covered under the Plan.
- Abdominoplastys (unless covered under GA-46000, the Amtrak Early Retirement Plan, the Keolis Commuter Services (formerly MBCR) Early Retirement Plan, or the TransitAmerica Services, Inc. (TASI) Early Retirement Plan).
- [Alternative Treatments, such as acupressure, aromatherapy, hypnotism, massage therapy, rolfing, and art therapy, music therapy, dance therapy, horseback therapy and other forms of alternative treatment as defined by the *National Center for Complementary and Alternative Medicine (NCCAM)* of the *National Institutes of Health.]*
- Breast reduction surgery (unless covered under GA-46000, the Amtrak Early Retirement Plan, the Keolis Commuter Services (formerly MBCR) Early Retirement Plan, ~~or~~ the TransitAmerica Services, Inc. (TASI) Early Retirement Plan, or Medicare).
- Chelation therapy, except to treat heavy metal poisoning.
- Completion of claim forms, or missed appointments.
- Cosmetic/Reconstructive Surgery - Cosmetic or reconstructive surgery or treatment, whether or not it is for psychological or emotional reasons, except for reconstructive surgery to improve the function of a body part when the malfunction is a direct result of one of the following:
  - Birth defect
  - Sickness
  - Injury which occurs while the individual is covered under this policy
  - Surgery

  The following reconstructive surgery is also covered:

  - Reconstructive breast surgery following a mastectomy, including surgery on the non-affected breast to achieve symmetry. Additional services include breast prosthesis and treatment of physical complications during all stages of the mastectomy including lymphedemas.
  - Reconstructive surgery to remove scar tissue on the neck, face or head if the scar tissue is due to injury which occurs or a sickness which commences while the individual is covered under this policy.

- Court Ordered Treatment - Examinations or treatment ordered by a court in connection with legal proceedings except as specifically provided under this policy.
- Coverage Under Other Railroad Health Plans - any confinement, treatment, services or supplies if benefits are payable for these expenses under any other employer group health plan as an Employee. Any premium payments made under this policy for any month that coverage is provided under any other employer group health plan will be refunded upon your request. Contact UnitedHealthcare for assistance.
- Custodial Care (see Definitions), except as specifically covered under Plan F.
- Drugs, including the following:
  - Prescription drug products for outpatient use that are filled by a prescription order or refill.
  - Self-injectable medications. This exclusion does not apply to medications which, due to their characteristics (as determined by UnitedHealthcare), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting.
  - Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and consumed in the Physician's office.
  - Over-the-counter drugs and treatments.
  - Growth hormone therapy (unless covered under GA-46000, the Amtrak Early Retirement Plan, the Keolis Commuter Services (formerly MBCR) Early Retirement Plan, ~~or~~ the TransitAmerica Services, Inc. (TASI) Early Retirement Plan, or Medicare).
- Durable Medical Equipment does not include any of the following items:
  - Non-hospital beds, comfort beds, motorized beds/mattresses.
  - Devices and computers to assist in communication and speech except for speech aid prosthetics and traceo-esophaeal voice prosthetics.
  - Wigs in excess of [$500 per calendar year] and/or for reasons other than loss of hair resulting from treatment of a malignancy or permanent loss of hair from an accidental injury.
  - Dental braces.
  - Braces that straighten or change the shape of a body part, except those braces that stabilize an injured body part and braces to treat curvature of the spine.
  - Air-conditioners, humidifiers, dehumidifiers, air purifiers and filters, and personal comfort items.
  - Durable Medical Equipment provided to you by a Physician.
  - Generally, any device, appliance, pump, machine stimulator, or monitor that is fully implanted into the body.
- Ecological or environmental medicine, diagnosis and/or treatment.
- Education, training and bed and board while confined in an institution which is mainly a school or other institution for training, a place of rest, a place for the aged or a nursing home.
- Eye examinations, glasses or contact lenses for diagnosis or treatment of refractive errors except to the extent needed for repair of damages caused by bodily injury sustained while covered (unless covered under GA-46000, the Amtrak Early Retirement Plan, the Keolis Commuter Services (formerly MBCR) Early Retirement Plan, ~~or~~ the TransitAmerica Services, Inc. (TASI) Early Retirement Plan or Medicare).
- Ear examinations, hearing aids or cochlear implants for diagnosis or treatment of hearing loss except due to the extent needed for repair of damages caused by bodily injury sustained while covered (unless covered under GA-46000, the Amtrak Early Retirement Plan, the Keolis Commuter Services

(formerly MBCR) Early Retirement Plan, ~~or~~ the TransitAmerica Services, Inc. (TASI) Early Retirement Plan or Medicare).

- Experimental or Investigational or Unproven Services and all services related to Experimental or Investigational and Unproven Services are excluded. The fact that an Experimental or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particual condition.
- Herbal medicine, holistic or homeopathic care, including drugs.
- Services, supplies medical care or treatment given by one of the following members of the Employee's immediate family:
  - The Employee's spouse.
  - The child, brother, sister, parent or grandparent of either the Employee or the Employe's spouse.
- Charges for procedures which facilitate a pregnancy but do not treat the cause of infertility, such as in vitro fertilization, artificial insemination, embryo transfer, gamete intrafallopian transfer, zygote intrafallopian transfer and tubal ovum transfer.
- Medical, surgical, diagnostic, psychiatric, substance abuse or other health care services, technologies, supplies, treatments, procedures, drug therapies or devices that, at the time UnitedHealthcare Insurance Company makes a determination regarding coverage in a particular case are determined to be:
  - not approved by the U.S. Food an Drug Administration ("FDA") to be lawfully marketed for the proposed use and not identified in the American Formulary Service, or the United States Pharmacopoeia Dispensing Information, as appropriate for the proposed use; or
  - subject to review and approval by any institutional review board for the proposed use; or
  - the subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight; or
  - a service that does not meet the definition of a Covered Health Service.

  If a Covered Person has a "life-threatening" Sickness or condition (one which is likely to cause death within one year of the request for treatment), UnitedHealthcare may determine that an Experimental, Investigational or Unproven Service meets the definition of a Covered Health Service for the Sickness or condition. For this to take place, UnitedHealthcare must determine that the service uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.
- Services and supplies which the Covered Person is not legally required to pay.
- Liposuction.
- Surgical correction or other treatment of a malocclusion.
- Services and supplies which are not Covered Health Services, including any confinement or treatment given in connection with a service or supply which is not covered under the Plan.
- Membership costs for health clubs, weight loss clinics and similar programs.
- Nutritional counseling except if provided for diabetes self-management training.
- Services given by a pastoral counselor.

- Personal convenience items, including but not limited to such items as TV's, telephones, first aid kits, exercise equipment, air conditioners, humidifiers, saunas and hot tubs.
- Private duty nursing services.
- Routine foot care, including but not limited to, nail cutting and trimming and removal of corns and calluses, except when required for the prevention of complications due to diabetes or severe systemic disease.
- Services for a surgical procedure to correct refractive errors of the eye, including any confinement, treatment, services or supplies given in connection with or related to the surgery.
- Sterilization procedures, except to avoid a life-threatening condition.
- Reversal of sterilization.
- Rhytidectomy.
- Sensitivity training, educational training therapy or treatment for an education requirement.
- Charges made by a Hospital for a confinement in a special area of the Hospital which provides non-acute care, by whatever name called, including but not limited to the type of care given by the facilities listed below. If that type of facility is otherwise covered under this Plan, then benefits for that covered facility which is part of a Hospital, as defined, are payable at the coverage level for that facility, not at the coverage level for a Hospital.
    - Adult or child day care center.
    - Ambulatory Surgical Center.
    - Birth Center.
    - Half-way house.
    - Hospice.
    - Skilled Nursing Facility.
    - Treatment Center.
    - Vocational rehabilitation center.
    - Any other area of a Hospital which renders services on an inpatient basis for other than acute care of sick, injured or pregnant persons.
- Stand-by services required by a Physician.
- Dental Services - care of and treatment to the teeth and gums except for the following:
    - Hospital, radiology and pathology services while confined as an in- patient in a Hospital for dental surgery or within 72 hours of dental surgery, and
    - Full or partial dentures, fixed bridgework, or repair to natural teeth if needed because of accidental injury to natural teeth which happens while covered.
- Dental Implants
- Treatment or consultations provided via audio only telephone, email messages or fax transmissions.
- Transplant services that are not performed at a Transplant Facility. This exclusion applies to Plans A, B and C only.

- Tobacco dependency.
- Services or supplies received as a result of war declared or undeclared, or international armed conflict.
- Weight reduction or control (unless there is a diagnosis of morbid obesity).
- Special foods, food supplements, liquid diets, diet plans or any related products.
- Wigs or toupees (except for loss of hair resulting from treatment of a malignancy or permanent loss of hair from an accidental injury costing under [$500 per calendar year]), hair transplants, hair weaving or any drug if such drug is used in connection with baldness.
- Services given by volunteers or person who do not normally charge for their services.
- Donor Expenses - expenses incurred by an organ donor, except as specifically provided under this Policy.
- Government Hospital –
    - for any confinement in a United States government or agency hospital. However, the reasonable cost incurred by the United States or one of its agencies for in-patient or out-patient medical care and treatment given by a military hospital may be covered under the Plan. This coverage applies only to care and treatment provided to:
        - A person retired from the uniformed services,
        - a family member of a person who is retired from the uniformed services,
        - a family member of a person who is active in the uniformed services, or
        - a family member of a deceased member of the uniformed services.
- Educational rehabilitation, or treatment of learning disabilities, regardless of the setting in which such services are provided.
- Treatment for personal or professional growth, development, or training or professional certification.
- Evaluation, consultation, or therapy for educational or professional training or for investigational purposes relating to employment.
- Examinations, testing, evaluations or treatment which may be required solely for purposes of obtaining or maintaining employment or insurance, pursuant to judicial order or administrative proceedings, or as may be required to participate in sports or attend school, to travel, or for the purposes of marriage or adoption.
- Academic education during residential treatment.
- Therapies such as Erhard/The Forum, primal therapy, aversion therapy, bioenergetic therapy, crystal healing therapy.
- Counseling services and/or treatment related to such problems as financial, marital or occupational difficulties, adult anti-social behavior or parent-child relationships.
- Non-abstinence based or nutritionally based chemical dependency treatment.

If a person is covered under this policy as a dependent of two Employees, benefits payable under this policy will be limited to the benefits for which only one of the Employees is entitled to on account of the expenses incurred in connection with the Dependent.

In no event will benefits under Plans A, B, C, E, M, or P be payable for any expenses incurred by any person on or after the date he or she becomes a Person Eligible Under Medicare.

Expenses incurred for services and supplies that the policy would not normally cover will be considered for payment of benefits if they are part of an "Alternate Care Plan (ACP)" that has been developed by UnitedHealthcare and agreed to by you or your dependent as a substitute for services and supplies that you or your Dependent are eligible for under the policy. Benefits for services and supplies provided under the Alternate Care Plan are subject to and count towards the policy's provisions regarding benefit amounts, maximum benefits, copayments and deductibles that apply to the services and supplies for which they are in substitution.

[X
BENEFITS AFTER COVERAGE ENDS

Plans A, B and C

If you or your Dependent is disabled on the date your coverage ends, Major Medical Expense Benefits apply to expenses incurred in the calendar year in which your coverage ends and the next succeeding calendar year, but only for the bodily injury or sickness causing continuous disability of you or your Dependent from the date your coverage ends, except that benefits are not payable on or after the date the disabled person becomes a Person Eligible Under Medicare.

Maternity benefits apply to expenses incurred after coverage ends in connection with a pregnancy which commenced while you or your Dependent wife was covered. The disability requirements stated above do not apply.

The Treatment Center Services benefits apply to confinements that began while you were covered.

Plan F

Treatment Center Expense Benefits apply to confinements that began while you were covered.

All other benefits are not provided under Plan F for expenses incurred after coverage ends.

Plans E, M and P

If you or your Dependent is disabled on the date your coverage ends Major Medical Expense Benefits will continue to apply subject to the following conditions: Benefits are payable only for expenses incurred with respect to your or your Dependent's bodily injury or sickness causing the disability.

The disability must be continuous from the date coverage ends to the date each expense is incurred.

Benefits are payable for the calendar year in which coverage ends and during the next calendar year.

Benefits are not payable for expenses incurred by any person on or after the date he or she becomes a Person Eligible Under Medicare.

Treatment Center Expense Benefits apply to confinements that began while you were covered.]

[XI]
DEFINITIONS

Alternate Care Plan

A plan of alternate utilization of medical services which includes cost-effective appropriate care alternatives to services which are otherwise covered by the policy. The alternate medical services may not be otherwise covered by the policy.

Ambulatory Surgical Center

A specialized facility which fully meets all the tests set forth in (1) or (2) below:

(1) Has been licensed as an ambulatory surgical center in accordance with the applicable laws in the jurisdiction in which it is located by the state's regulatory authority, as being established, equipped, operated and staffed primarily for the purpose of performing surgical procedures; or

(2) Where state licensing is not required, meets all of the following requirements:

- It is established, equipped and staffed primarily for the purpose of performing surgical procedures.
- It is operated under the supervision of a licensed doctor of medicine (M.D.) or doctor of osteopathy (D.O.) who is devoting full time to such supervision and permits a surgical procedure to be performed only by a duly qualified physician who, at the time the procedure is performed, is privileged to perform such procedure in at least one hospital in the area.
- It requires in all cases other than those requiring only local infiltration anesthetics, that a licensed anesthesiologist administer the anesthetic or supervise an anesthetist who is administering the anesthetic and that the anesthesiologist or anesthetist remain present throughout the surgical procedure.
- It provides at least one operating room and at least one post- anesthesia recovery room.
- It is equipped to perform diagnostic X-ray and laboratory examinations or has an arrangement to obtain such, as necessary.
- It has trained personnel and necessary equipment to handle emergency situations.
- It has immediate access to a blood bank or blood supplies, if necessary.
- It provides the full-time services of one or more registered graduate nurses (R.N.) for patient care in the operating room and in the post-anesthesia recovery room.
- It maintains an adequate medical record for each patient, such record to contain an admitting diagnosis including, for all patients except those undergoing a procedure under local anesthesia, a preoperative examination report, medical history and laboratory tests and/or X-rays, an operative report and a discharge summary.

Amtrak Early Retirement Plan

The Amtrak Union Retiree Benefit Plan.

Assistant Surgeon Services

Where necessary, the services of an assistant surgeon are limited to one-fifth of the amount of Covered Expenses for the surgeon's charge for the surgery.

Birth Center

A specialized facility which is primarily a place for delivery of children following a normal uncomplicated pregnancy and which fully meets one of the following two tests:

- It is licensed by the regulatory authority having responsibility for such licensing under the laws of the jurisdiction in which the facility is located.
- Where licensing is not required, it meets all of the following requirements:
    - It is operated and equipped in accordance with any applicable state law.
    - It is equipped to perform routine diagnostic and laboratory examinations.
    - It has trained personnel and necessary equipment available to handle foreseeable Emergencies.
    - It is operated under the full-time supervision of a doctor of medicine (M.D.) or registered nurse (R.N.)
    - It maintains a written agreement with at least one Hospital in the area for immediate acceptance of patients who develop complications.
    - It is expected to discharge or transfer patients within 24 hours following delivery.

Chemotherapy

The treatment of malignant conditions using antineoplastic agents which are administered:

- at a controlled rate through a catheter placed surgically in an artery,
- intramuscularly,
- subcutaneously, or
- orally.

Antineoplastic agents are those chemotherapy drugs which have been accepted for inclusion in the U.S. Pharmacopoeia, National Formulary, or have been accepted by the Federal Drug Administration and/or have received official approval by the American Medical Association Council on Drugs.

COBRA

Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Convenient Care Clinic

A health care facility typically located in a high-traffic retail store, supermarket or pharmacy that provides affordable treatment for uncomplicated minor illness and/or preventive care to consumers. Please contact Member Services (phone number located on the back of your Member Indentifcation Card) to locate a Convenient Care Clinic.

Covered Health Service(s)

Covered Health Services are those health services, supplies or equipment provided for the purpose of preventing, diagnosing or treating a Sickness, Injury, Mental Illness, substance abuse, or symptoms. Covered Health Services must be provided:

- When the Plan is in effect;
- Prior to the date that any of the individual termination conditions set forth in this Certificate of Coverage; and
- Only when the person who receives services is a Covered Person and meets all eligibility requirements specified in the Plan.

A Covered Health Service must meet each of the following criteria:

- It is supported by national medical standards of practice.
- It is consistent with conclusions of prevailing medical research that demonstrates that the health service has a beneficial effect on health outcomes and are based on trials that meet the following designs:
    - Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)
    - Well-conducted cohort studies. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)
- It is the most cost-effective method and yields a similar outcome to other available alternatives.
- It is a health service or supply that is described in this Certificate, and which is not excluded under General Exclusions.

Decisions about whether to cover new technologies, procedures and treatments will be consistent with conclusions of prevailing medical research, based on well-conducted randomized trials or cohort studies, as described.

Custodial Care

Care made up of services and supplies that meets one of the following conditions:

- Care furnished mainly to train or assist in personal hygiene or other activities of daily living, rather than to provide medical treatment.
- Care that can safely and adequately be provided by persons who do not have the technical skills of a covered health care professional.
- Care that meets one of the conditions above is custodial care regardless of any of the following:

- Who recommends, provides or directs the care.
- Where the care is provided.
- Whether or not the patient can be or is being trained to care for himself or herself.

Dependent

With respect to Plans A, B, C, E, and F ~~and M~~

- The Employee's spouse,
- The Employee's unmarried children from birth through age 18,
- The Employee's unmarried children 19 years of age but under 25 years of age, who have their legal residence with the Employee, and who are wholly dependent upon the Employee for maintenance and support and who are registered Students in regular, full-time attendance at an accredited secondary school, college or university or institution for the training of nurses, and
- The Employee's unmarried children 19 years of age or over who have their legal residence with the Employee and who are wholly dependent upon the Employee for maintenance and support and who have a permanent physical or mental condition which is such that they are unable to engage in any regular employment, provided that such disability began prior to the child attaining 19 years of age.

Please note, in order to continue Dependent coverage past age 19, you must contact UnitedHealthcare and notify us of your Dependent's Student status or disability. In addition, proof of Student status or disability may be required.

[With respect to Plan M

- Any dependent of the Employee that is covered under the Keolis Commuter Services (formerly MBCR) Early Retirement Plan.

With respect to Plan P

- ~~The Employee's spouse,~~
- ~~The Employee's same-sex domestic partner or same-sex civil union partner who meets the rules set by your employer.~~
- ~~The Employee's unmarried children from birth through age 26, and~~
- ~~The Employee's handicapped child who's coverage is continued beyond age 26 under~~ Any dependent of the Employee that is covered under the Amtrak Early Retirement Plan or the TransitAmerica Services, Inc. (TASI) Early Retirement Plan.]

Durable Medical Equipment – medical equipment that is all of the following:

- Can withstand repeated use.
- Is not disposable.
- Is used to serve a medical purpose with respect to treatment of a sickness, injury or their symptoms.
- Is generally not useful to a person in the absence of a sickness, injury or their symptoms.
- Is appropriate for use, and is primarily used, within the home.
- Generally, is not implantable within the body.

Employee

A U.S. resident who is classified as one of the following:

- a currently inactive railway employee who was covered as an active employee under one of the following plans:
  - ~~Health & Welfare Plan~~Railroad Employees National Health and Welfare Plan .
  - [NRC/UTU Plan].
  - Any other health and welfare plan established pursuant to an agreement between one or more railroads and one or more labor organizations.
- A currently retired or disabled railway industry employee who is covered under The Railroad Employees National Early Retirement Major Medical Benefit Plan (GA-46000) or any other group health plan deemed by UnitedHealthcare to provide benefits identical to those provided under GA-46000.
- A currently retired or disabled railway industry employee who is covered under the Keolis Commuter Services (formerly MBCR) Early Retirement Plan or any other group health plan deemed by UnitedHealthcare to provide benefits identical to those provided under the Keolis Commuter Services (formerly MBCR) Early Retirement Plan.
- A currently retired or disabled railway industry employee who is covered under the Amtrak Early Retirement Plan or the TransitAmerica Services, Inc. (TASI) Early Retirement Plan or any other group health plan deemed by UnitedHealthcare to provide benefits identical to those provided under the Amtrak Early Retirement Plan.
- A currently inactive Cooperating Railway Labor Organization employee who was covered as an active employee under the Railway Labor Organizations Group Life and Hospital, Surgical and Medical Benefit Plan for Their Officers and Employees (GA-107300).
- With respect to coverage for parents and parents-in-law under Plan F, an active or Inactive Employee covered under GA-23111, ~~Health & Welfare Plan~~Railroad Employees National Health and Welfare Plan, [NRC/UTU Plan], GA-46000, the Amtrak Early Retirement Plan, the Keolis Commuter Services (formerly MBCR) Early Retirement Plan, the TransitAmerica Services, Inc. Early Retirement Plan or GA-107300.

Experimental or Investigational or Unproven Service(s)

Medical, surgical, diagnostic, psychiatric, substance abuse or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time UnitedHealthcare makes a determination regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the *U.S. Food and Drug Administration* (FDA) to be lawfully marketed for the proposed use and not identified in the *American Hospital Formulary Service* or the *United States Pharmacopoeia Dispensing Information* as appropriate for the proposed use.
- Subject to review and approval by an institutional review board for the proposed use (Devices which are FDA approved under the *Humanitarian Use Device* exemption are not considered to be Experimental or Investigational.)
- The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical test set forth in the FDA regulations, regardless of whether the trial is actully subject to FDA oversight.

Exceptions:

- Life-Threatening Sickness or Condition. If you have a life-threatening sickness or condition (one that is likely to cause death within one year of the request for treatment) UnitedHealthcare may, at its discretion, consider an otherwise Experimental or Investigational or Unproven Service to be a Covered Health Services for that sickness or condition. Prior to such a consideration, UnitedHealthcare must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that sickness or condition, and that the service would be provided under standards equivalent to those defined by the *National Institutes of Health*.

Full Medicare Coverage

Coverage for all the benefits provided under both Medicare Part A and Medicare Part B. For the purpose of coverage under this policy, each Person Eligible Under Medicare shall be deemed to have Full Medicare Coverage.

Full Medicare Coverage will include any benefit which could have been provided under Medicare, but which are not provided under Medicare for any of the following reasons:

- The person is not enrolled in Medicare.
- The person is enrolled in a Medicare Advantage Plan.
- The person receives services from a provider who has elected to opt-out of Medicare.
- The person is enrolled under a plan with a Medicare Savings Account.
- Medicare benefits are reduced because of any benefits paid in accordance with:
  - any plan of insurance regulated by or through action of any automobile reparations act of any government,
  - any policy or plan which includes automobile medical payments benefits,
  - the provisions of any liability insurance policy or plan, or
  - the availability of health coverage under a group health plan which must pay benefits primary to Medicare.

Furloughed Employee

The term "Furloughed Employee" as used herein means an Employee furloughed or placed on leave of absence while covered for Employee or Dependents benefits under the ~~Health & Welfare~~Railroad Employees National Health and Welfare Plan, ~~or~~ [NRC/UTU Plan], GA-107300 [,GA-46000, Amtrak Early Retirement Plan, Keolis Commuter Services (formerly MBCR) Early Retirement Plan or TransitAmerica Services, Inc. (TASI) Early Retirement Plan]. The term Furloughed Employee shall also include:

- any individual whose coverage under the ~~Health & Welfare~~Railroad Employees National Health and Welfare Plan or [NRC/ UTU Plan] is terminated but whose status is being considered in proceedings under the Railway Labor Act, as certified by the Policyholder; and
- any Employee on furlough or leave of absence who was covered as a Furloughed Employee under the Former Policy; and
- any individual whose insurance under the ~~Health & Welfare~~Railroad Employees National Health and Welfare Plan or [NRC/ UTU Plan] is terminated following the termination of his or her employment relationship by a reason of his or her change in the Employer's practices or method of operation, such as a merger, consolidation or abolition of the individual's position, but in no event beyond date such individual becomes covered under a health and welfare plan.

Wherever reference is made herein to employment, furlough or being placed on a leave of absence, it shall mean employment, furlough or being placed on leave of absence by the Employer included under the ~~Health & Welfare~~Railroad Employees National Health and Welfare Plan or [NRC/UTU Plan] or GA-107300 by whom the Employee was last employed prior to the termination of his or her coverage under such plans.

In no event shall the term Furloughed Employee include any individual beyond the termination of any such furlough or leave.

GA-107300

Railway Labor Organizations Group Life Insurance and Hospital, Surgical and Medical Benefit Plan for Their Officers and Employees. Any reference to any other employer group health plan is a reference to GA-107300.

GA-46000

The Railroad Employees National Early Retirement Major Medical Benefit Plan and any other group health plan which is determined by UnitedHealthcare to provide benefits identical to the Railroad Employees National Early Retirement Major Medical Benefit Plan.

~~**Health & Welfare Plan**~~

~~The Railroad Employees National Health and Welfare Plan and AmPlan.~~

Home Health Care Agency

An agency or organization which provides a program of home health care and which fully meets one of the following three tests.

- It is approved under Medicare.
- It is established and operated in accordance with the applicable licensing and other laws.
  - It meets all of the following tests:
  - It has the primary purpose of providing a home health care delivery system bringing supportive services to the home.
  - It has a full-time administrator.
  - It maintains written records of services provided to the patient.
  - Its staff includes at least one registered graduate nurse (R.N.) or it has nursing care by a registered graduate nurse (R.N.) available.
  - Its employees are bonded and it provides malpractice and malplacement insurance.

Hospice

An agency that provides counseling and incidental medical services for a terminally ill individual. The agency must meet all of the following tests:

- It is approved under any required state or governmental Certificate of Need.
- It provides 24 hour-a-day, 7 day-a-week service.
- It is under the direct supervision of a physician**.**
- It has a social-service coordinator who is licensed in the area in which it is located.
- The main purpose of the agency is to provide Hospice services.
- It has a full-time administrator.

- It is established and operated in accordance with any applicable state laws.

A part of a Hospital that meets the criteria set forth above will be considered as a Hospice for the purpose of this policy.

Hospital

An institution which is engaged primarily in providing medical care and treatment of sick and injured persons on an in-patient basis at the patient's expense and which fully meets all the tests set forth in (a) or (b) or (c) below:

(a) It is a hospital accredited by the Joint Commission on Accreditation of Health Care Organizations.

(b) It is a hospital~~,~~ or a psychiatric hospital ~~or a tuberculosis hospital~~, as those terms are defined in Medicare, which is qualified to participate and eligible to receive payments under and in accordance with the provisions of Medicare.

(c) It is an institution which fully meets all of the following tests:

- It maintains on the premises diagnostic and therapeutic facilities for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of duly qualified physicians; and
- It continuously provides on the premises twenty-four hour a day nursing service by or under the supervision of registered graduate nurses; and
- It is operated continuously with organized facilities for operative surgery on the premises.

Inactive Employee

Former railroad or union employees who were covered as active employees under the ~~Health & Welfare Plan~~Railroad Employees National Health and Welfare Plan, [NRC/UTU Plan], GA-107300, [GA-46000, Amtrak Early Retirement Plan, Keolis Commuter Services (formerly MBCR) Early Retirement Plan or TransitAmerica Services, Inc. (TASI) Early Retirement Plan] who were terminated from active employment for one of the following reasons:

- Furlough as defined above under Furloughed Employee.
- Suspension or dismissal.
- Retirement.
- Termination of employment relationship for reasons other than retirement or dismissal.
- Disability.

Keolis Commuter Services (formerly MBCR) Early Retirement Plan

Level of Care

The duration, frequency, location, intensity and/or magnitude of a treatment setting, treatment plan, or treatment modality, including, but not limited to:

- acute care facilities;
- less intensive inpatient or outpatient alternatives to acute care facilities such as residential treatment centers, group homes or structured outpatient programs;
- outpatient visits; or
- medication management.

Medical Judgment

Judgment with respect to any of the following issues in connection with a claim for benefits:

- medical necessity;
- appropriateness of care;
- health care setting;
- level of care;
- effectiveness of a covered benefit; or
- a determination of whether a treatment or a procedure is experimental or investigational.

Medically Appropriate

A Covered Health Service which has been determined by UnitedHealthcare to be the appropriate Level of Care that can safely be provided for the specific covered individual's diagnosed condition in accordance with the professional and technical standards adopted by UnitedHealthcare .

Medicare

The Health Insurance for The Aged and Disabled program under Title XVIII of The Social Security Act as such Act was amended by the Social Security Amendments of 1965 (Public Law 89-97), 1967 (Public Law 90-248) and 1972 (Public Law 92-603), as such program is currently constituted and as it may be later amended.

Multiple Surgical Procedures

Multiple surgical procedures means more than one surgical procedure performed during the same operative session. Covered Expenses for multiple surgical procedures are limited as follows:

- Covered Expenses for a secondary procedure are limited to 50% of the Covered Expenses that would otherwise be considered for the secondary procedure had it been performed during a separate operative session.
- Covered Expenses for any subsequent procedure are limited to 50% of the Covered Expenses that would otherwise be considered for the subsequent procedure had it been performed during a separate operative session.

Nurse-Midwife

A person who is certified to practie as a Nurse-Midwife and who:

- Is licensed as a registered nurse by the appropriate board of nursing having responsibility for such licensure under the laws of the jurisdiction where such person renders services, and
- Has completed a program for the training of Nurse-Midwives approved by the appropriate regulatory authority having responsibility for such programs under the laws of the jurisdiction where such program is provided.

[NRC/UTU Plan

National Railway Carriers and United Transportation Union Health & Welfare Plan.]

Person Eligible Under Medicare

An Employee or Dependent who is enrolled under Medicare Parts A and B or has been eligible to enroll under Medicare Parts A and B.

Under Plan E, if the basis for Medicare coverage is end stage renal disease, an Employee or Dependent shall not be a Person Eligible Under Medicare until the end of a 30 month period beginning with the first day of the person's Medicare eligibility.

Physician

A legally qualified:

- Doctor of Medicine (M.D.)
- Doctor of Chiropody (D.S.C.)
- Doctor of Chiropractic (D.C.)
- Doctor of Dental Surgery (D.D.S.)
- Doctor of Medical Dentistry (D.M.D.)
- Doctor of Optometry (O.D.)
- Doctor of Osteopathy (D.O.)
- Doctor of Podiatry (D.P.M.)
- [Provider, other than those listed above, who is properly licensed in the state in which he or she is practicing, that delivers services that may also be delivered by a medical doctor.]
- Physician's Assistant when operating under the direction of one of the above Physicians.

Policy

The entire agreement issued to the Policyholder, that includes the following:

- the Group Policy
- this Certificate of Coverage
- Amendments
- Riders

These documents make up the entire agreement that is issued to the Policyholder.

Policyholder

The following organizations collectively constitute the Cooperating Railway Labor Organizations to whom the policy is issued.

- [International Brotherhood of Boilermakers, Iron Ship Builders, Blacksmiths, Forgers and Helpers
- International Brotherhood of Electrical Workers
- National Conference of Firemen and Oilers/SEIU
- International Association of Machinists and Aerospace Workers
- SMART Mechanical Department
- Transportation Communications Union/IAM
- Brotherhood of Maintenance of Way Employes Division/IBT

- Brotherhood of Railroad Signalmen
- Brotherhood of Locomotive Engineers and Trainmen Division/IBT
- [SMART Transportation Division]
- American Train Dispatchers Association
- Transport Workers Union]

Preferred Provider

A provider who has agreed to discount his or her charges for Covered Services under Plans A, B, C, E, M and P.

Psychologist

A person who specializes in clinical psychology and fulfills one of the following requirements:

- A person licensed or certified as a psychologist.
- A Member or Fellow of the American Psychological Association, if there is no government licensure or certification required.

Wherever reference is made to a licensed physician, it will also include a psychologist.

Railroad Employees National Health and Welfare Plan

Reasonable Charge

An amount measured and determined by UnitedHealthcare by comparing the actual charge with the charges made for similar services and supplies provided to individuals of similar age, sex, circumstances and medical condition in the locality concerned.

In determining the Reasonable Charge for a service or supply that is:

- unusual; or
- not often provided in the same area; or
- provided by only a small number of providers in the area:

Factors such as the following may be taken into account:

- the complexity;
- the degree of skill needed;
- the type of specialty of the provider;
- the range of services or supplies provided by a Facility; and
- the prevailing charge in other areas.

Skilled Nursing Facility

It is an institution which meets the following tests:

- It is operated under the applicable licensing and other laws.
- It is under the supervision of a Physician, or registered graduate nurse (R.N.), who is devoting full time to supervision.

- It is regularly engaged in providing room and board and continuously provides 24 hour a day skilled nursing care of sick and injured persons at the patient's expense during the convalescent stage of an injury or sickness.
- It maintains a daily medical record of each patient who is under the care of a Physician.
- It is authorized to administer medication to patients on the order of a Physician.
- It is not, other than incidentally, a home for the aged, the blind or the deaf, a hotel, a domiciliary care home, a maternity home, or a home for alcoholics or drug addicts or the mentally ill.

Student

The term "Student" as used herein is limited to the Employee's unmarried children 19 years of age but under 25 years of age, who have their legal residence with the Employee, and who are wholly dependent upon the Employee for maintenance and support and who are registered students in regular, full-time attendance at an accredited secondary school, college or university orinstitution for the training of nurses.

TransitAmerica Services, Inc. (TASI) Early Retirement Plan

Transplant Facility

A Hospital that UnitedHealthcare specifically designates as a transplant facility. A Transplant Facility has entered into an agreement with UnitedHealthcare to render Covered Health Services for the treatment of specified diseases or conditions. A Transplant Facility may or may not be located within your geographic area. The fact that a Hospital is a network hospital does not mean that it is a Transplant Facility.

Treatment Center

An institution which does not qualify as a Hospital but which does provide a program of effective medical and therapeutic treatment for alcoholism and/or chemical dependency and meets all the following requirements:

- It is established and operated in accordance with any applicable state law.
- It provides a program of treatment approved by a Physician and UnitedHealthcare.
- It has or maintains a written, specific and detailed regimen requiring full-time residence and full-time participation by the patient.
- It provides at least the following basic services:
  - Room and board.
  - Evaluation and diagnosis.
  - Counseling.
  - Referral and orientation to specialized community resources.

Urgent Care Center

A facility that provides Covered Health Services that are required to prevent serious deterioration of one's health, and that are required as a result of an unforeseen sickness, injury, or the onset of acute or severe symptoms.

[XII]

CLAIM INFORMATION

HOW TO FILE A CLAIM FOR BENEFITS

PLANS A, B AND C

In order for UnitedHealthcare to process your medical claims as fast as possible, the following steps should be taken when you incur medical expenses:

- Send your medical bills to UnitedHealthcare, [P.O. Box 30985, Salt Lake City, UT 84130].
- Generally, medical bills will include information such as employee name, employee address and name of patient which are needed to process your claims. In addition to these items of information, it is very important that the employee's **social security number, policy number** "GA-23111" and **nature of illness or injury** appear on each submission of bills to avoid any unnecessary delay in the payment of your claim.

Upon receipt of your claim, UnitedHealthcare will immediately furnish any additional form required in accordance with the kind of claim presented. In most cases, additional forms will not be required.

PLAN F

Claims under Plan F are paid in UnitedHealthcare's office at [P.O. Box 30304, Salt Lake City, UT 84130]. For expenses not covered under Medicare, send itemized bills to Salt Lake City. Be sure to include the Employee's social security number and the policy number (GA-23111).

To submit claims for expenses also covered under Medicare, the provider of services must first file a claim with Medicare. The Medicare contractor will then send an Explanation of Medicare Benefits (EOMB).

If your Medicare claim is paid in any Medicare office where UnitedHealthcare has arranged for an automatic transfer of Medicare claim information, you will not have to file a separate claim to receive Plan F benefits. Instead, after Medicare processing has been completed, these claims will automatically be filed under Plan F.

If your Medicare claim is not paid in any Medicare office where UnitedHealthCare has arranged for an automatic transfer of Medicare claim information, you will have to file a separate claim with UnitedHealthcare to receive Plan F benefits. To do so, send a copy of the Explanation of Medicare Benefits (EOMB) you receive to UnitedHealthcare's Salt Lake City office. Be sure to include the Employee's name, social security number and policy number (GA-23111) on the EOMB.

You can always know whether your Medicare claim has been automatically transferred to Plan F, or whether you have to file a separate claim to receive Plan F benefits, by looking at your EOMB. Your EOMB will have a message telling you that your claim was forwarded. The message may not specifically tell you that your claim was transferred to UnitedHealthcare, but it will make some reference that it was sent to another carrier. If you do not receive this message on your EOMB, you will have to file a separate claim to receive Plan F benefits.

PLAN E

Benefits will be paid under Plan E automatically with no additional action required on your part. Follow the instructions in your GA-46000 booklet for submission of claims.

PROCESSING OF CLAIMS AND APPEALS

Overview

The claims and appeal procedures under the **Policy** consist of the steps explained below. You must exhaust the internal claims and appeals process as explained below before filing any judicial action against the **Policy** on a claim denied in whole or in part. A "claim" is a request for required pre-approval for care or treatment to be covered by the **Policy** or for reimbursement or payment by the **Policy** for care or treatment you have already received. These claims and appeals procedures also apply to any rescission of coverage, whether or not a claim is involved.

Here is a summary of the process:

Step 1 – You must file an initial claim

This claim will be processed and reviewed within specified time frames, depending on whether it is a "pre-service request" or a "post-service request."

Step 2 – If your claim is denied, you may make an informal inquiry

If your initial claim is denied in whole or in part, you have the opportunity to make an informal inquiry into the reasons for the denial. You should generally receive an answer to your inquiry within 60 days. This informal inquiry process is not mandatory and does not impact your formal appeal rights.

Step 3 – You have the right to a formal appeal if your initial claim is denied

If your initial claim is denied in whole or in part you have two formal appeals levels:

1. The first level of appeal which is required for all claims, must be made to UnitedHealthcare.

2. The second level of appeal is a right that is available to you if you so choose.

Each part of the process is explained more fully below.

Step 1 – Initial Claim Processing

Explanation of Benefits Will be Provided. If, in order to receive full benefits, you request required pre-approval of services involving Urgent Care, you will receive verbal notification followed by a written or electronic Explanation of Benefits informing you of the determination made with regard to your request. For all other claims, you will receive a written or electronic Explanation of Benefits informing you of the benefit determination.

The Explanation of Benefits will be written in a manner that can be understood by you. If the decision is adverse to you, the Explanation of Benefits will contain the following information related to your claim: (1) the reasons for the decision, including a denial code and its corresponding meaning; (2) a description of the standard, if any, that was used in denying the claim; (3) references to specific **Policy** provisions that explain the decision; (4) information sufficient to identify the claim involved (including the date of the service, the health care provider, the claim amount if applicable, and a statement describing the availability, upon request, of the diagnosis and treatment codes and their corresponding meanings); (5) an explanation of any additional material or information that may be necessary to perfect your claim and why that information is necessary; (6) a description of the applicable internal appeal procedure and external review processes; (7) a reference to any rule, guideline, protocol, or similar criterion that was relied upon in making the decision, or a statement that such information will be provided at no charge upon request; (8) either an explanation of the scientific or clinical judgment involved or a statement that

such an explanation will be provided to you at no charge upon request, if the adverse decision is based on a judgment about medical necessity, experimental treatment, or a similar **Policy** exclusion or limitation; (9) a statement about your rights to bring an action in court if the decision is still adverse to you once you complete the appeal process; and (10) contact information for an applicable office of health insurance consumer assistance or ombudsman.

Time Periods and Process for Urgent Care Initial Claims

If you are requesting required pre-approval for Urgent Care in order to obtain full benefits and a prior authorization is involved, then the following will apply:

- A health care professional with knowledge of your medical condition may act as your authorized representative for the purpose of your request.

- If your request was not made properly, you will be provided with verbal notification of the proper procedure for making the request as soon as possible, but no later than 24 hours from the receipt of your request.

- If your request is made properly and all necessary information is included, you will be provided with verbal notification of the determination made upon your request as soon as possible, but no later than 72 hours from the receipt of your request.

- If additional information is required to make a determination on your request, you will be provided with verbal notification of the additional information required to complete your request as soon as possible, but no later than 24 hours from receipt of your request.

    - You will have 48 hours after receipt of this notification to provide the additional information.

    - You will then be provided with verbal notification of the determination on your request as soon as possible, but no later than 48 hours after the earlier of:

        - the receipt of the additional information; or

        - the end of the 48-hour period in which you have to provide the additional information.

- If an Urgent Care request for ongoing treatment was previously approved for a period of time or a number of treatments, and you request an extension of that treatment, you will be provided with verbal notification of the determination on your request as soon as possible, but no later than 24 hours from the receipt of your request, provided your request is made at least 24 hours before the termination of care. Otherwise, you will be provided with verbal notification of the determination no later than 72 hours from the receipt of your request.

- For all requests for required pre-approval of services involving Urgent Care, a written or electronic copy of the determination will be sent to you within 3 days following verbal notification.

- Your request will no longer be processed as involving Urgent Care if you go ahead and receive the care or treatment for which you seek pre-approval. Instead, your request will be processed as a post-service claim for reimbursement.

Time Periods and Process For Non-Urgent Initial Claims

The time periods and process for initial claims depends on whether the claim involves a "pre-service request" or a "post-service request" as explained below.

Pre-Service Requests

If, in order to receive full benefits, you request required pre-approval of care or treatment, the following will apply:

- If your request was not made properly, you will be notified verbally or in writing within 5 days from the receipt of your request of the proper procedure for making the request.

- If your request is made properly, a notice of determination regarding your request will be sent to you no later than 15 days after receipt of your request. UnitedHealthcare may take an additional 15 days to make a determination if it determines that such an extension is necessary for reasons beyond its control and notifies you of this extension within 15 days from the receipt of your request. This notice will give you the reason for the extension and the date by which the determination will be made.

- If an extension is necessary because additional information is required to make the determination, you will be notified of the specific information that is needed.

    - You will have 45 days after receipt of this notice to provide the additional information.

    - The period for making a determination on your request will be suspended until you either provide the necessary information or until the 45-day period for you to provide the information ends, whichever comes first.

- If a request to pre-approve ongoing treatment was previously approved for a period of time or a number of treatments, and UnitedHealthcare wants to reduce or terminate the treatment, you will be notified promptly.

- Your request will no longer be processed as a pre-service request if you go ahead and receive the care or treatment for which you seek pre-approval. Instead, your request will be processed as a post-service claim for reimbursement.

Post-Service Requests

When you seek reimbursement or payment for care or treatment that you have already received, your claim will be handled as follows:

- You will ordinarily be notified as to whether your claim will be paid or denied (in whole or in part) no later than 30 days after the receipt of your claim.

- UnitedHealthcare may take an additional 15 days to make a benefit determination if it determines that such an extension is necessary due to matters beyond its control and notifies you of this extension within 30 days from the receipt of your claim. This notice will give you the reason for the extension and the date by which the benefit determination will be made.

- If additional information is required to make a benefit determination, the notice will state this and identify the additional information required.

    - You have 45 days after receipt of this notice to provide the additional information.

- The period for making a benefit determination on your claim will be suspended until you either provide the necessary information or until the 45-day period for you to provide the information ends, whichever comes first.

Step 2 – Informal Inquiries Following Claim Denials

If a claim has been denied in whole or in part, and you have questions about the reasons for the denial or you disagree with the reasons, you may make an informal inquiry by telephone about the reasons for the denial to UnitedHealthcare.

The Explanation of Benefits that you receive denying your claim in whole or in part will set forth the name and telephone number of the appropriate office to contact if you would like to make an informal inquiry concerning your claim for benefits. You are not required to make an informal inquiry before you initiate any formal appeal, but an informal inquiry could lead you to understand better the reasons for the claim denial, or it could result in a change in the way your claim is handled. Informal inquiries concerning claim denials must be made within 60 days after you receive your Explanation of Benefits and will be addressed promptly.

Step 3 – Formal Appeals of Claim Denials: Rights and Procedures

The formal appeals process for denied claims consists of a first and second level appeal process as explained below.

First Level of Appeal for all Claim Denials – To the Company Administering Your Benefit

If you are dissatisfied with the handling of your claim following informal inquiry, or even if you do not make an informal inquiry, you may make a formal written appeal of a denied claim to UnitedHealthcare.

Your Explanation of Benefits will include information explaining how to initiate this formal appeal and the name and address of the office to which the formal appeal should be sent. All formal appeals must be initiated by a written request for a formal appeal. Your request for a formal appeal must be submitted within one hundred eighty (180) days after you receive your Explanation of Benefits or, if you make a timely informal telephone inquiry concerning the denial of your claim, within one hundred eighty (180) days after you make that informal inquiry.

You may submit additional information with your written request for formal appeal. Your formal appeal may include evidence and testimony, and written comments, documents, records and other information relating to the claim for benefits (regardless of whether such information was considered in the initial claim for benefits). You are also entitled, upon request and at no charge, to receive access to and copies of all documents, records, and other information relevant to your claim, although in some cases approval may be needed for the release of confidential information such as medical records. UnitedHealthcare, considering your formal appeal, will provide you with new or additional evidence considered, relied upon, or generated it, or at its direction and any additional rationale for a denial prior to appeals decision in order to give you a reasonable opportunity to respond to the new evidence or rationale. This information will be provided sufficiently in advance of the date by which UnitedHealthcare must provide the claims denial notice, to give you the opportunity to respond to the new or additional information. The decision made on your appeal will take into account all comments, documents, records, and other information you submit relating to your claim, regardless of whether the information was submitted or considered as part of the initial determination on your claim.

All decisions of first level appeals will be made without any deference to the initial decision on your claim. The individual who decides your formal first level appeal will not be the same person who initially decided your claim, nor will he or she be a subordinate of that person. If the benefits decision under review is based on a medical judgment, the individuals reviewing your appeal will consult with a health care professional who has appropriate training and experience. That health care professional will not be a

person who was consulted in connection with the initial decision on your claim nor will he or she be a subordinate of a person consulted on the initial decision.

You will be notified of the decision on your formal appeal in writing or electronically (except as noted below). The written or electronic notice will be written in a manner calculated to be understood by you, will specify the reasons for the decision, including a denial code and its corresponding meaning, and a description of the standard, if any, that was used in denying your claim, including a discussion of the decision, will contain a reference to specific plan provisions relevant to the decision, and a statement that you may receive, upon request and at no charge, reasonable access to and copies of documents and information relevant to your claim for benefits. The notice will also specify any rule, guideline, or protocol relied on in deciding your appeal, or an offer to provide such rule, guideline or protocol at no charge upon request. The notice will also identify any medical experts whose advice was obtained on behalf of the **Policy** in connection with your claim, even if the advice was not relied on in making a benefit decision. The notice will also include a description of your right to bring an action under ERISA Section 502(a) after you complete the appeal process. You may appeal an adverse decision on your formal first level appeal as described below.

Final (Second Level) Appeal

The second level of the appeal process is explained below. There are two possible second level appeal processes – one for claims that do not involve **Medical Judgment** and one for claims that do involve **Medical Judgment**. A decision on your formal second level appeal will be final, except that you may appeal that decision to a court (see below).

Claims Not Involving Medical Judgment

If you are dissatisfied with the results of any initial appeal of your claim denial to UnitedHealthcare that does not involve **Medical Judgment**, you may file an additional appeal with UnitedHealthcare. Your request for an appeal must be submitted within ninety (90) days after you receive the results from your initial appeal, and the process for filing an appeal will be included with the results from your initial appeal.

Claims Involving Medical Judgment – To an External Independent Review Organization

If your claim involves **Medical Judgment** (excluding those that involve only contractual or legal interpretation without any use of **Medical Judgment**), and you exhaust the first level of appeal procedure (or earlier, if you are deemed to have exhausted such procedure due to the **Policy's** failure to comply with the procedure), you will have the right to request a second level of appeal, which will consist of an independent review with respect to that claim. You must request this appeal/independent review within four months after receiving notice of an adverse benefit determination or final internal adverse benefit determination.

Within five business days after receiving your request, a preliminary review will be completed to determine whether: (i) you are/were covered under the **Policy**; (ii) the denial was based on an issue involving **Medical Judgment**; (iii) you exhausted the internal claims and appeals process, if required; and (iv) you provided all information necessary to process the independent review. Within one business day after completing the preliminary review, you will be notified in writing if your request is not eligible for an independent review or if it is incomplete. If your request is complete but not eligible for independent review, the notice will include the reason(s) for ineligibility. If your request is not complete, the notice will describe any information needed to complete the request. You will have the remainder of the four month filing period or 48 hours after receiving the notice, whichever is greater, to cure any defect. If eligible for an independent review, your request will be assigned to an independent review organization (IRO). The IRO will provide written notice of its final independent review decision within 45 days after the IRO receives the request for independent review. If the IRO reverses the adverse benefit determination or final internal adverse benefit determination, then the Plan will cover the claim.

In addition, you will have the right to an expedited independent review in the following situations:

1. Following an adverse benefit determination involving a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal.

2. Following a final internal adverse benefit determination involving (i) a medical condition for which the timeframe for completion of a standard independent review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function or (ii) an admission, availability of care, continued stay, or health care item or service for which you received emergency services but have not been discharged from a facility.

The IRO will provide notice of its final independent review decision as expeditiously as the claimant's medical condition or circumstances require, but not more than 72 hours after the IRO receives the request.

Formal Appeals of Claim Denials: Timeframes for Receiving a Determination

Following is a summary of the timeframes for receiving a determination on your appeal of a denied claim.

Urgent Care Appeals – Claims Not Involving Medical Judgment

Your appeal may require prompt action if you are appealing the denial of your request for required pre-approval of Urgent Care and a prior authorization is involved. In these situations:

- Your appeal need not be in writing. You or your **Physician** can request a review by telephone. All necessary information, including the decision, will be transmitted verbally, by telephone, by facsimile, or by similar means.

- You will be notified verbally and in writing or electronically as soon as possible, but no later than 72 hours from receipt of your appeal.

- Your appeal will no longer be processed as appealing a denial of a request for pre-approval for urgent care or treatment if you go ahead and receive the care or treatment for which you seek pre-approval. Instead, your appeal will be processed as a post-service claim for reimbursement.

Non-Urgent Care Appeals

Pre-Service

If you are appealing the denial of your request for required pre-approval for medical care services or treatment or the termination or reduction of benefits for medical care or treatment, your appeal will be handled as follows:

- A decision following the review of your first level appeal by UnitedHealthcare will be sent to you within 15 days from the day your appeal of the denial is received.

- If you file a final (second level) appeal with UnitedHealthcare with respect to a claim not involving **Medical Judgment**, a decision will be sent to you within 15 days from the day your appeal is received.

- If you file a final (second level) appeal with respect to a claim involving **Medical Judgment**, the IRO's decision will be sent to you within 45 days from the day your appeal is received by the IRO.

- Your appeal will no longer be processed as appealing a denial of a request for pre-approval for care or treatment if you go ahead and receive the care or treatment for which you seek pre-approval. Instead, your appeal will be processed as a post-service claim for reimbursement.

Post-Service

If you are appealing the denial of benefits for care or treatment that you have already received, your appeal will be handled as follows:

- A decision following the review of your appeal by UnitedHealthcare will be sent to you within 30 days after your appeal of the denial is received.

- If you file a final (second level) appeal with UnitedHealthcare with respect to a claim not involving **Medical Judgment**, a decision will be sent to you within 30 days from the day your appeal is received.

- If you file a final (second level) appeal with respect to a claim involving **Medical Judgment**, the IRO's decision will be sent to you within 45 days from the day your appeal is received by the IRO.

External Appeals

If you have exhausted the appeals process described in this Certificate, and you are still dissatisfied with the resolution of an appeal involving the medical appropriateness of a service, you may contact the Director, Office of the Health Care Ombudsman and Bill of Rights at the following:

For Medical Appropriateness cases:
District of Columbia Department of Health Care Finance
Office of the Health Care Ombudsman and Bill of Rights
825 North Capital Street, N.E.
6th Floor
Washington, DC 20002
Telephone - 1-877-685-6391
Facsimile – 202-478-1397

If you have exhausted the appeals process described in this Certificate, and you are still dissatisfied with the resolution of an appeal involving anything other than the medical appropriateness of a service, you may contact the Commissioner of Insurance at the following:

For Non-Medical Appropriateness cases:
Gennet Purcell, Commissioner
Department of Insurance, Securities and Banking
810 First St., N.E., 7th Floor
Washington, DC 20002
Telephone – 202-727-8000
Facsimile – 202-354-1085

PROOF OF LOSS

UnitedHealthcare may:

- require bills for Hospital confinement and other services as part of the proof of claim.
- examine you or your Dependent in connection with the claim.

Proof must be furnished to UnitedHealthcare no later than 90 days after the loss for which the claim is made. If it is not reasonably possible to furnish the proof in this time it must be furnished at the earliest reasonable possible date.

If your state of residence requires that you have more time to furnish proof, you will have the time allowed by your state.

PAYMENT OF CLAIMS

Employee and Dependents health benefits are payable to the Employee.

Employee and Dependents health benefits which are assigned will be paid to the assignee. The Employee will receive notice of payment of assigned benefits.

All benefits will be paid upon receipt of proper written proof.

ACTIONS

You may not sue on your claim before 60 days after proof of claim has been furnished to UnitedHealthcare or more than three years from the time proof of claim is required.

If your state of residence requires that you have more time to bring suit, you will have the time allowed by your state.

IMPORTANT MESSAGE FOR RETIREES OF KEOLIS COMMUTER SERVICES (FORMERLY MBCR) COVERED UNDER PLAN M

The Keolis Commuter Services (formerly MBCR) Plan is referred to below as your Primary Plan.

PLAN M CLAIM SUBMISSION

To submit claims under Plan M, follow these two steps:

1. First, file a claim under your Primary Plan.
2. After you receive an Explanation of Benefits (EOB) from your Primary Plan, send an itemized bill with a copy of the EOB to UnitedHealthcare, P.O. Box 30985, Salt Lake City, UT 84130-0985. Be sure to include the employee's name, social security number, policy number (GA-23111 Plan M) and nature of the illness or injury with each claim submission.

COBRA CONTINUATION UNDER THE PRIMARY PLAN

Any dependent who elects to continue Primary Plan coverage under COBRA may also continue coverage under Plan M, provided you notify UnitedHealthcare within 30 days of the COBRA election. If you elect to continue Plan M, you must also notify UnitedHealthcare when COBRA coverage ends.

Expenses incurred after Primary COBRA coverage ends for any reason are not Covered Expenses under Plan M. Any Plan M benefits paid for expenses incurred after Primary Plan COBRA coverage ends, due to your failure to notify UnitedHealthcare, are subject to recovery by UnitedHealthcare.

IMPORTANT MESSAGE FOR RETIREES OF AMTRAK AND TRANSITAMERICA SERVICES, INC. (TASI) COVERED UNDER PLAN P

The Amtrak Early Retirement Medical Plan or the TransitAmerica Servicse, Inc. (TASI) Early Retirement Plan is referred to below as your Primary Plan.

PLAN P CLAIM SUBMISSION

To submit claims under Plan P, follow these two steps:

1. First, file a claim under your Primary Plan.
2. After you receive an Explanation of Benefits (EOB) from your Primary Plan, send an itemized bill with a copy of the EOB to UnitedHealthcare, P.O. Box 30985, Salt Lake City, UT 84130-0985. Be sure to include the employee's name, social security number, policy number (GA-23111 Plan P) and nature of the illness or injury with each claim submission.

COBRA CONTINUATION UNDER THE PRIMARY PLAN

Any dependent who elects to continue Primary Plan coverage under COBRA may also continue coverage under Plan P, provided you notify UnitedHealthcare within 30 days of the COBRA election. If you elect to continue Plan P, you must also notify UnitedHealthcare when COBRA coverage ends.

Expenses incurred after Primary COBRA coverage ends for any reason are not Covered Expenses under Plan P. Any Plan P benefits paid for expenses incurred after Primary Plan COBRA coverage ends, due to your failure to notify UnitedHealthcare, are subject to recovery by UnitedHealthcare.

[NOTICE OF PRIVACY PRACTICES

GROUP POLICY GA-23111

Effective Date: September 23, 2013

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We, meaning UnitedHealthcare Insurance Company, as the issuer of Group Policy GA-23111, and any of our affiliated or subsidiary companies, including, but not limited to, United Behavioral Health (collectively referred to herein as "United"), are required by law to protect the privacy of your protected health information. As used in this notice, the terms "We", "Us" and "Our" refer not only to United itself, but also to any agents or contractors acting on its behalf, including those entities that United has retained to administer the benefits it provides. Federal law prohibits Us from disclosing your health information to an agent or contractor unless that agent or contractor has agreed in writing to maintain the privacy of your health information.

We are required to provide this notice. It explains how We use protected health information about you and when We disclose that information to others. Federal law requires Us to use and disclose your protected health information only as described in this notice. We are also required by law to honor your rights with respect to your protected health information that are described in this notice. We are also required to provide you notice promptly if a breach occurs that may have compromised the privacy or security of your information.

The term "protected health information" as used in this notice includes any personal information that relates to your physical or mental health condition, the provision of health care to you, or the payment for such health care. The provisions of this notice apply to protected health information that is created by Us or received by Us from others.

If We make a material change to our privacy practices, We will provide a revised notice or information about the material change and how to obtain a revised notice, to you and it will be provided either by direct mail or electronically, in accordance with applicable law.

We collect and maintain oral, written and electronic information to administer your health plan and to provide products, services and information of importance to enrollees. We maintain physical, electronic and procedural security safeguards in the handling and maintenance of such information, in accordance with applicable state and federal standards, to protect against risks, such as loss, destruction or misuse.

How We Use and Disclose Your Protected Health Information

Required Uses and Disclosures

We must use and disclose your protected health information to provide information:

- To you or a representative with the legal right to act for you;
- To the Secretary of the Department of Health and Human Services, if necessary, to ensure that your privacy is protected; and
- When required by law; for example, a court could order Us to disclose protected health information in its possession for the purpose of litigation.

Permitted Uses and Disclosures

We have the right to use and disclose protected health information to pay for your health care and manage the provision of benefits to you. We will use or disclose your protected health information only as permitted by law, including the federal Privacy Rule for protected health information. For example, We may, consistent with the Privacy Rule, use or disclose your protected health information for the following purposes:

- Payment. Payment activities include, among other things, collecting contributions due to Us and paying for health care services provided to you. For example, We may receive information from a doctor concerning treatment provided to you. We may review that information to evaluate whether the treatment is eligible for coverage under your health plan. We may also use your protected health information for purposes of making preauthorization determinations for certain types of benefits.

- Treatment. We may use or disclose protected health information for the purpose of assisting health care professionals in their efforts to provide you with medical treatment. For example, We may disclose your protected health information to facilitate referrals between doctors or to coordinate your treatment among health care providers.

- Health Care Operations. We may use or disclose protected health information as necessary to operate your health plan and to manage coverage under that plan. For example, We may use your protected health information to analyze trends in the coverage We provide or to set contribution levels. Other ways in which your protected health information may be used for health care operations include quality assessment and improvement activities, audits of performance under the your health plan, cost management and planning-related analyses, review of the qualifications of health care professionals, administration of your health plan's activities in general, and arrangement for medical review or legal services. We may disclose your protected health information to others for the purpose of conducting health care operations. For example, We may contact your doctor to suggest a disease management or wellness program that could help improve your health.

- Communications with You. We may contact you to provide information about health related products or services such as alternative medical treatments available to you under your health plan. We may use your protected health information to identify programs and treatments that would be most beneficial to you. We may also contact you to provide appointment reminders for your medical treatment.

- Disclosures to the Policyholder. Your health plan is governed by the Policyholder. The Policyholder is defined in your health plan's Certificate of Coverage. We may share statistical information about usage under your health plan and enrollment and disenrollment information with the Policyholder. In addition, We may share other protected health information with the Policyholder solely for purposes of plan administration. Neither We nor the Policyholder will share your protected health information with your employer without your express written authorization or as may be permitted under applicable law.

- Underwriting Purposes. We may use or disclose your protected health information for underwriting purposes; however We will not use or disclose your genetic information for such purposes. Generally, genetic information involves information about differences in a person's DNA that could increase or decrease his or her chance of getting a disease (for example, diabetes, heart disease, cancer or Alzheimer's disease).

Other Uses and Disclosures Permitted by Law

We may, consistent with the federal Privacy Rule for protected health information, use or disclose your protected health information for the following purposes under limited circumstances:

- Disclosure for Public Health Purposes. We may be required to disclose your protected health information for public health activities, such as reporting disease outbreaks or adverse reactions caused by a prescription drug.
- Disclosure to Persons Involved with Your Care. We may disclose your protected health information to a person involved in your care, such as a family member, when you are incapacitated or in an emergency, or when permitted by law. Special rules apply regarding when We may disclose protected health information to family members and others involved in a deceased individual's care. We may disclose protected health information to any persons involved, prior to the death, in the care or payment for care of a deceased individual, unless We are aware that doing so would be inconsistent with a preference previously expressed by the deceased.
- Disclosure to Report Abuse, Neglect or Domestic Violence. We may be required to disclose your protected health information to government authorities, including a social service or protective service agency, to help them identify and aid victims of abuse, neglect, or domestic violence.
- Disclosure for Health Oversight Activities. We may be required to disclose your protected health information to government officials responsible for overseeing health insurers, health care providers, government benefit programs, or civil rights laws relating to health care.
- Disclosure in Judicial or Administrative Proceedings. We may be required to disclose your protected health information in response to a court order, search warrant or subpoena or other lawful process.
- Disclosure for Law Enforcement Purposes. We may be required to disclose your protected health information to law enforcement officials for limited purposes, such as missing person investigations.
- Disclosure to Avoid a Serious Threat to Health or Safety. We may be required to disclose your protected health information to public health agencies.
- Disclosure for Workers Compensation. We may be required to disclose protected health information arising out of job-related injuries pursuant to applicable laws.
- Disclosure for Specialized Government Functions. We may be required to disclose limited information for military and veteran activities, national security and intelligence activities, and the protective services for the President and other public officials.
- Use or Disclosure for Research Purposes. We may use or disclose protected health information for research purposes subject to limitations imposed by law.
- Disclosure to Coroners or Medical Examiners. We may disclose protected health information to a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also disclose information to funeral directors as necessary to carry out their duties.
- Disclosure for Organ Procurement Purposes. We may use or disclose information for procurement, banking or transplantation of organs, eyes or tissue.
- Disclosure to Correctional Institutions or Law Enforcement Officials. We may disclose your protected health information if you are an inmate of a correctional institution or under the custody of a law enforcement official, but only if necessary, (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

- Disclosure to Business Associates. We may disclose your protected health information to our business associates that perform functions on your health plan's behalf or provide your health plan with services, if the protected health information is necessary for such functions or services. Our business associates are required, under contract with Us and pursuant to federal law, to protect the privacy of your protected health information and are not allowed to use or disclose any information other than as specified in Our contract and as permitted by federal law.

- Disclosure for Data Breach Notification Purposes. We may disclose your contact information to provide legally-required notices of unauthorized acquisition, access, or disclosure of your protected health information. We, or Our business associates, may send notice directly to you.

Whenever We disclose your protected health information for a purpose permitted by the federal Privacy Rule, We are required to disclose only the minimum amount of information necessary to serve that purpose.

If none of the above reasons applies, **then We must get your written authorization to use or disclose your protected health information.** This includes, except for limited circumstances allowed by federal privacy law, not using or disclosing psychotherapy notes about you, selling your protected health information to others, or using or disclosing your protected health information for certain promotional communications that are prohibited marketing communications under federal law, without your written authorization. Once you authorize disclosure of your protected health information, We cannot guarantee that the person to whom the information is provided will not disclose the information. You may revoke your written authorization, unless We have already acted based on your authorization. To revoke an authorization, contact the privacy office identified below.

In some states, state law may impose restrictions on the use or disclosure of protected health information more stringent than those described in this notice. For example, some states may require plans to obtain a person's express authorization before using or disclosing his or her protected health information for the purposes described above. We will comply with such state laws to the extent they apply to your health plan.

Your Rights with Respect to Your Protected Health Information

The following are your rights with respect to your protected health information.

- Restrictions on Uses and Disclosures of Your Protected Health Information. You have the right to ask Us to agree to restrictions on the uses or disclosures We make of your protected health information for purposes of treatment, payment, or health care operations. You also have the right to ask Us to impose restrictions on disclosures of your protected health information to family members or to others who are involved in your health care or payment for your health care. While We will try to honor your request and will permit requests consistent with Our policies, We are not required to agree to any restriction. If We determine that We cannot accommodate your request to restrict uses or disclosures of your protected health information for the purposes of treatment, payment, or health care operations, We will provide you with reasonable notice of Our decision.

- Restrictions on Methods of Communications from Us. You have the right to ask Us to restrict Our communications with you to a more confidential mode of communication or to contact you at a different address. We will accommodate reasonable requests to communicate in a confidential format.

- Inspection of Protected Health Information. You have the right to inspect and obtain a copy of certain protected health information maintained about you by Us, such as claims and case or medical management records. If We maintain your protected health information electronically, you will have the right to request that We send you a copy of your protected health information in an electronic format. You can also request that We provide a copy of your information to a third party that you identify. You also may receive a summary of this protected health information. A request to inspect or copy your protected health information, or have your information sent to a third party, must be made in writing to the address provided below. In certain limited circumstances, We may deny your request to inspect and copy your protected health information. We may impose a reasonable fee reflecting the actual costs of copying, mailing or preparing a summary of your protected health information.

- Amendment of Protected Health Information. You have the right to ask Us to amend certain protected health information We maintain about you, such as claims and case or medical management records, if you believe that the information is inaccurate or incomplete. You must make such a request in writing to the address provided below. If We deny your request, you may have a statement of your disagreement added to your protected health information.

- Accounting of Disclosures of Protected Health Information. You have the right to ask Us to provide you with an accounting of certain disclosures of your protected health information made by Us during the six years prior to your request. This accounting will not include disclosures of information: (i) made for treatment, payment, and health care operations purposes; (ii) made to you or pursuant to your authorization; (iii) made to correctional institutions or law enforcement officials; or (iv) other disclosures for which federal law does not require Us to provide an accounting.

- Paper Copy of This Notice. You may ask for a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

How to Exercise Your Rights

- Contacting Us. For further information about the privacy of your protected health information, to obtain a copy of this notice, or to ask Us to agree to restrict the ways in which it uses or discloses your protected health information, contact Our privacy compliance officer at the following address or phone number:

  UnitedHealthcare
  Customer Service – Privacy Unit
  P.O. Box 30985
  Salt Lake City, UT 84130
  Tel: 1-800-842-5252

- Filing a Complaint. If you believe your privacy rights have been violated, you may file a written complaint with Us at the following address:

  UnitedHealthcare
  Customer Service – Privacy Unit
  P.O. Box 30985
  Salt Lake City, UT 84130

You may also notify the Secretary of the U.S. Department of Health and Human Services if you feel We have violated your rights. You can file a complaint with the U.S. Department of Health Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20001, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

We will not take any action against you for filing a complaint.

- Exercising Your Rights With Respect to Your Protected Health Information. You are entitled to inspect, copy or amend certain protected health information maintained by or on behalf of Us, to request an accounting of disclosures of certain protected health information, or to ask that communications from Us be made in a confidential manner or place.]

INFORMATION REQUIRED BY THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (“ERISA”)

The following information together with this booklet form the Summary Plan Description under the Employee Retirement Income Security Act of 1974, sometimes called "ERISA."

- Name of Plan:

  Group Health Insurance Plans For Former Railroad Employees and their Dependents Provided Under Group Policy GA-23111

- Plan Identification Numbers:

  Employer Identification Number (EIN): 53-6001877
  Plan Number (PN): 503

- Plan Administrator:

  Cooperating Railway Labor Organizations
  c/o Transportation Communications Union/IAM
  3 Research Place
  Rockville, MD 20850

  The Plan Administrator has authority to control and manage the operation and administration of the Plan and is the agent for service of legal process.

- Type of administration of the Plan: The Plan is administered directly by the Plan Administrator.

  The Plan’s offerings are provided primarily by the Plan named above with claims being paid by UnitedHealthcare Insurance Company, Hartford, Connecticut 06103 in accordance with the provisions of the Group Policy GA-23111 issued by UnitedHealthcare Insurance Company, Hartford, Connecticut 06103.

- Funding:

  The Plan is funded by premium payments made directly to UnitedHealthcare by individuals covered under the Plan, as required by the insurance policies.

- Source of contributions to the Plan:

  Premium payments made by individuals covered under the Plan.

- Date of the end of the Plan Year:

  Each Plan Year ends on a May 31.

- Claim Procedures:

  See pages [151] through [155] of this Certificate for requirements as to notice and proof of claim.

- How to Appeal a Claim:

  See pages [155] through [158] of this Certificate for what action to take when appealing a claim.

- Plan Amendment and Termination:

  The Cooperating Railway Labor Organizations have the right to modify, suspend, terminate, withdraw or amend the Plan in whole or in part at any time. Amendments to the Plan must be adopted by a majority of the Organizations' members and evidenced by a written instrument signed by the Chairman of the Organizations.

  In event of termination of the Plan, the assets of the Plan will be used towards payment of obligations of the Plan and any remaining surplus will be distributed in the manner determined by the Plan Administrator to best effectuate the purposes of the Plan in accordance with the applicable regulations under ERISA.

As a participant in the Plan, you are entitled to certain rights and protections under ERISA, which provides that all Plan participants shall be entitled to:

- **Receive Information About Your Plan and Benefits**

  - Examine, without charge, at the Plan Administrator's office and at other locations, all documents governing the Plan, including insurance contracts and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions.

  - Obtain, upon written request to the Plan Administrator, copies of all Plan documents and other Plan information. The administrator may make a reasonable charge for the copies.

  - Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary financial report.

- **Continue Group Health Coverage**

  - Continue health care coverage for you or your dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. See the section of this Certificate that sets forth your **COBRA** continuation of coverage rights.

  - Reduce or eliminate exclusionary periods of coverage for preexisting conditions under the Plan, if any, as long as you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from the Plan or UnitedHealthcare when you lose coverage under the Plan, when you become entitled to elect **COBRA** continuation coverage, or when your **COBRA** continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage.

- **Prudent Action by Plan Fiduciaries**

  In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries," of the Plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

- **Enforce Your Rights**

  If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any detail, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights.

  - For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

  - If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court, but not until you exhaust the appeals process described in this Certificate.

  - In addition, if you disagree with the Plan's decision or lack thereof, concerning the qualified status of a medical child support order, you may file suit in Federal court, but not until you exhaust the appeals process described in this Certificate.

  - If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file a suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

- **Assistance with Your Questions**

  If you have any questions about the terms of the Plan or about the proper payment of benefits, you may obtain more information from the company described in this Certificate as administering the benefit program in which you participate or contact the Plan Administrator. If you have any questions about whether you are covered, you may obtain that information from your employer.

  If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

* * *

UnitedHealthcare does not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to the Civil Rights Coordinator.
Online: UHC_Civil_Rights@uhc.com
Mail: Civil Rights Coordinator. UnitedHealthcare Civil Rights Grievance. P.O. Box 30608 Salt Lake City, UT 84130

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again.
If you need help with your complaint, please call the toll-free phone number listed on your ID card, TTY 711, [Monday through Friday, 8 a.m. to 8 p.m].

You can also file a complaint with the U.S. Dept. of Health and Human Services.
Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.
Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)
Mail: U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201

We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call the toll-free phone number listed on your ID card TTY 711, [Monday through Friday, 8 a.m. to 8 p.m.].

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Please call the toll-free phone number listed on your identification card.

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número de teléfono gratuito que aparece en su tarjeta de identificación.

請注意：如果您說中文**(Chinese)**，我們免費為您提供語言協助服務。請撥打會員卡所列的免付費會員電話號碼。

XIN LƯU Ý: Nếu quý vị nói tiếng **Việt (Vietnamese)**, quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi số điện thoại miễn phí ở mặt sau thẻ hội viên của quý vị.

알림: **한국어(Korean)**를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 신분증 카드에 기재된 무료 회원 전화번호로 문의하십시오.

PAALALA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numero ng telepono na nasa iyong identification card.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **русском (Russian)**. Позвоните по бесплатному номеру телефона, указанному на вашей идентификационной карте.

تنبيه: إذا كنت تتحدث **العربية (Arabic)**، فإن خدمات المساعدة اللغوية المجانية متاحة لك. الرجاء الاتصال على رقم الهاتف المجاني الموجود على معرّف العضوية.

ATANSYON: Si w pale **Kreyòl ayisyen (Haitian Creole)**, ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nimewo gratis ki sou kat idantifikasyon w.

ATTENTION : Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro de téléphone gratuit figurant sur votre carte d'identification.

UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny numer telefonu podany na karcie identyfikacyjnej.

ATENÇÃO: Se você fala **português (Portuguese)**, contate o serviço de assistência de idiomas gratuito. Ligue gratuitamente para o número encontrado no seu cartão de identificação.

ATTENZIONE: in caso la lingua parlata sia l'**italiano (Italian)**, sono disponibili servizi di assistenza linguistica gratuiti. Per favore chiamate il numero di telefono verde indicato sulla vostra tessera identificativa.

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte rufen Sie die gebührenfreie Rufnummer auf der Rückseite Ihres Mitgliedsausweises an.

注意事項：**日本語(Japanese)**を話される場合、無料の言語支援サービスをご利用いただけます。健康保険証に記載されているフリーダイヤルにお電話ください。

توجه: اگر زبان شما **فارسی (Farsi)** است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. لطفا با شماره تلفن رایگانی که روی کارت شناسایی شما قید شده تماس بگیرید.

कृपा ध्यान दें: यदि आप **हिंदी (Hindi)** भाषी हैं तो आपके लिए भाषा सहायता सेवाएं नि:शुल्क उपलब्ध हैं। कृपा अपने पहचान पत्र पर दिए टाल-फ्री फ़ोन नंबर पर काल करें।

CEEB TOOM: Yog koj hais Lus **Hmoob (Hmong)**, muaj kev pab txhais lus pub dawb rau koj. Thov hu rau tus xov tooj hu deb dawb uas teev muaj nyob rau ntawm koj daim yuaj cim qhia tus kheej.

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយ**ភាសាខ្មែរ (Khmer)** សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទទៅលេខឥតគិតថ្លៃ ដែលមាននៅលើអត្តសញ្ញាណប័ណ្ណរបស់អ្នក។

PAKDAAR: Nu saritaem ti **Ilocano (Ilocano)**, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan iti toll-free a numero ti telepono nga nakalista ayan iti identification card mo.

DÍÍ BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yáníłti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shǫǫdí ninaaltsoos nitł'izí bee nééhozinígíí bine'dęę' t'áá jíík'ehgo béésh bee hane'í biká'ígíí bee hodíilnih.

OGOW: Haddii aad ku hadasho **Soomaali (Somali)**, adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac lambarka telefonka khadka bilaashka ee ku yaalla kaarkaaga aqoonsiga.

NOTES

November 11, 2016

Department of Insurance, Securities and Banking
Government of the District of Columbia
801 First Street, N.E., Suite 701
Washington, DC 20002

Re: UnitedHealthcare Insurance Company
NAIC No. 79413
2017 Rail Road Medical Certificate Filing

Dear Madam/Sir:

On behalf of UnitedHealthcare Insurance Company. I am submitting the enclosed certificate of coverage filing for your Department's review and approval.

This is an employee pay all plan designed to cover certain railroad employees and their dependents when their group health coverage under their employer-sponsored plans ends. If a former employee is not Medicare eligible, they can enroll in Plans A, B, or C. Plan F is for those who are Medicare eligible, and is similar to a Medicare Supplement Plan in that it provides coverage for certain benefits that may not be covered under Medicare or provides coverage beyond what is payable by Medicare. Plans E is only for those former employees who are also eligible for another railroad retiree plan - The Railroad Employees National Early Retirement Major Medical Benefit Plan (GA-46000). Plan M is only for former employees who were covered under the Keolis Commuter Services (formerly Massachusetts Bay Commuter Rail) Plan. Plan P is only for former employees of Amtrak or TransitAmerica, Inc. (TASI).

I have provided a clean copy of the new Certificate that as well as a redline version of the previously filed plan that was approved by your Department in 2015 under SERFF # UHLC-130022785, Form No. 50086886 (3/15). Most of the changes are corrections or the addition of information. The customer has directed us that the plan should now be an ERISA plan, so things like COBRA, Appeals, Information Required by ERISA, and Non-Discrimination Notice, have all been added. .

Form Name	Form Number	Flesch Score
Rail Road Certificate of Coverage	50086886 (1/17)	50.3

Explanation of Variable Text - is outlined within the document and I have also enclosed statement of variability documents as required by District of Columbia.

Included in these forms are the following features:

- Non-variable Text that always appears in an issued document.
- Variable Text that may or may not appear in an issued document depending on the specific product and plan design selected by the Enrolling Group. Variable text is enclosed in [brackets].

- Instruction text that is included, where necessary, to further explain the variability in the filed forms. Please note that any instruction text will appear only in the filed form and will not appear in the form issued to a Subscriber.

Information contained within these forms may also be used in an online format with appropriate changes in font, format and design to more easily accommodate online viewing or issuance. We want to assure the Department that education will be provided to the brokers regarding access and alternatives to electronic issuance.

If you have any questions or concerns regarding this submission, please feel free to call me at the number shown below.

Sincerely,

Esther Drew

Digitally signed by Esther Drew
DN: cn=Esther Drew, o=UnitedHealthcare, ou=Regulatory Affairs, email=esther_l_drew@uhc.com, c=US
Date: 2016.11.11 12:46:53 -05'00'

Esther Drew

Northeast Regulatory Affairs

UnitedHealthcare

4 Research Dr.

Shelton, CT 06484

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Phone: 203-447-4465